

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (41)
15M 7-62

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL ANNAPOLIS</u> c. LENGTH OF STAY IN 1b <u>ANNAPOLIS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>BAY MANOR NURSING HOME</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u> d. STREET ADDRESS <u>195 MAIN ST</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>MARY EDITH ADAMS</u> First Middle Last						4. DATE OF DEATH <u>NOV 3 1967</u> Month Day Year					
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT 10, 1884</u> Yrs. 83		9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>				11. BIRTHPLACE (County & State, or foreign country) <u>ANNAPOLIS MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM H. WARD</u>						14. MOTHER'S MAIDEN NAME <u>SARA WARD</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give year or dates of service)						16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>MRS LEILA ESLINGER</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Cholera</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
MEDICAL CERTIFICATION											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>10/30</u> <u>1967</u> to <u>11/3</u> <u>1967</u> , that (I) (we) last saw the deceased alive on <u>10/26</u> <u>1967</u> , and that death occurred at <u>10:30</u> <u>PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Richard I. Hochman, M.D.</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11/6/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Richard I. Hochman, M.D.</u>						22d. ADDRESS <u>16 Mainway Ave, Annapolis</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)					
<u>BURIAL</u>		<u>NOV 6, 1967</u>		<u>HILLCREST CEM.</u>		<u>ANNAPOLIS</u> <u>MARYLAND</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN M. TAYLOR - SONS</u>						ADDRESS <u>ANNAPOLIS MD</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE	

TO : DIRECTOR, FBI (100-441100)
FROM : SAC, NEW YORK (100-100000)
SUBJECT: [Illegible]

[The following text is extremely faint and largely illegible. It appears to be a memorandum or report containing several paragraphs of text, possibly including a summary, details, and a conclusion. Some words like "subject", "information", and "report" are faintly visible.]

[Illegible text continues]

CERTIFICATE OF DEATH

14775

14783

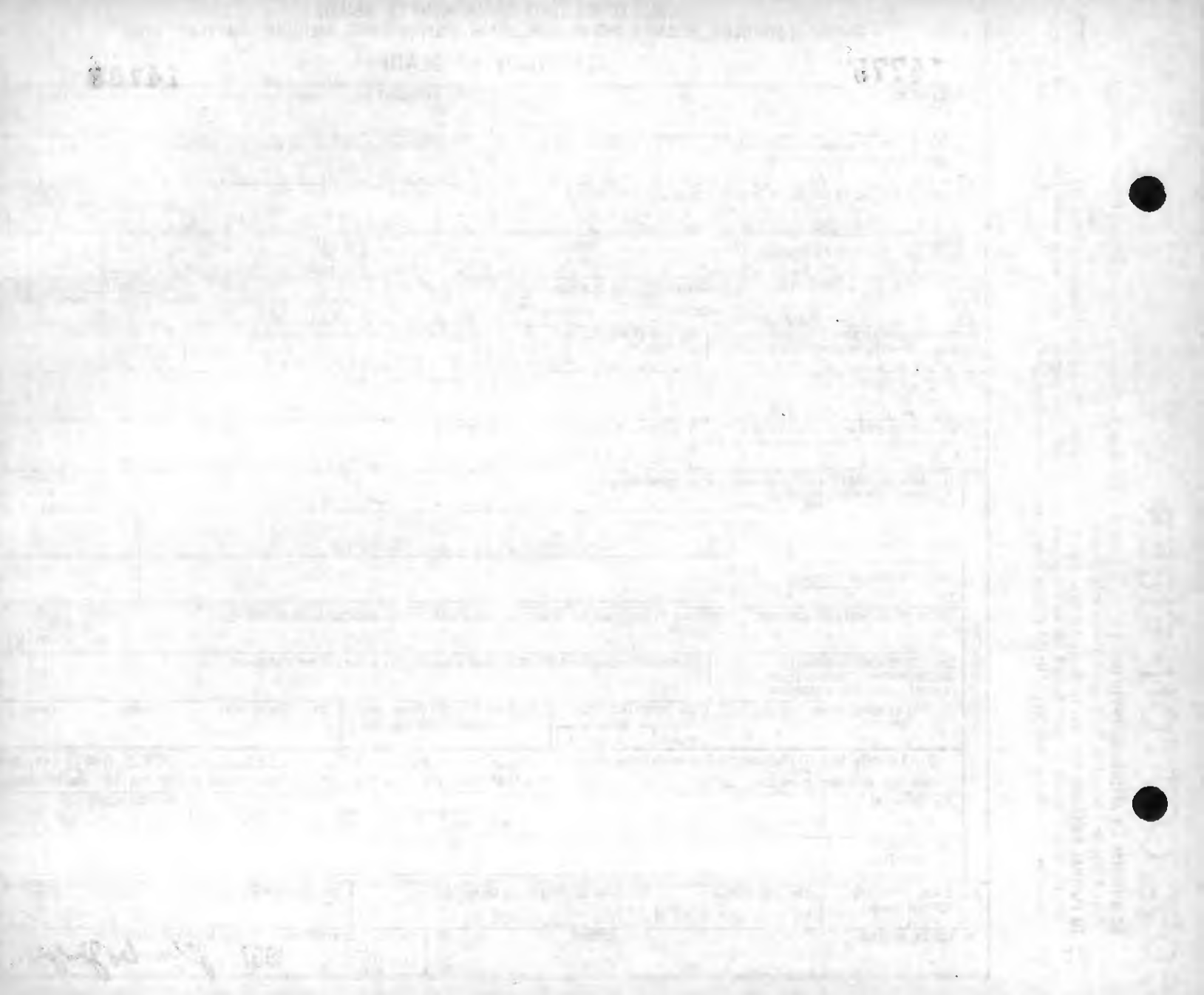
1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Glen Burnie</i>		c. LENGTH OF STAY IN 1b <i>1 1/2 yrs.</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Anne Arundel Co.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Glen Burnie</i>		d. STREET ADDRESS <i>137 South Meadow Dr.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <i>William B. Anderson</i>		4. DATE OF DEATH Month <i>November</i>		Day <i>28</i>		Year <i>1967</i>		5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>January 22, 1888</i>		9. AGE (In years lost birthday) <i>81</i> YRS.		10. IF UNDER 1 YEAR Months <i>0</i>		11. IF UNDER 24 HRS. Days <i>0</i>		Hours <i>0</i>		Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Plumber</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Harvey B. Foxley</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Baltimore City</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>		13. FATHER'S NAME <i>John Anderson</i>		14. MOTHER'S MAIDEN NAME <i>Margaret E. Turner</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>212-03-3405</i>		17. INFORMANT <i>Mrs M. E. Gore</i>		Address <i>137 S. Meadow Dr.</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <i>154x</i> IMMEDIATE CAUSE (a) <i>Carcinoma of rectum</i> DUE TO (b) <i>Carcinoma to his</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)														INTERVAL BETWEEN ONSET AND DEATH <i>18 mo</i>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)																	
21. I certify that (I) (this hospital) attended the deceased from <i>June 20, 1966</i> , to <i>Nov 28, 1967</i> , that (I) (we) last saw the deceased alive on <i>Nov 28, 1967</i> , and that death occurred at <i>6 A</i> M, from causes and on the date stated above.																									
22a. SIGNATURE <i>Robert Dabolin</i>								M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>11-28-67</i>															
22c. PHYSICIAN'S NAME (Type) <i>Robert Dabolin, M.D.</i>								22d. ADDRESS <i>400 Greenbury St. Elm St.</i>																	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE THEREOF <i>11-30-1967</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Morland Mem. Park</i>				23d. LOCATION (City or Town) (County) (State) <i>Balto. Md.</i>															
24. FUNERAL DIRECTOR <i>Lassahn Funeral Home</i>				ADDRESS <i>7401 Belair Rd</i>				25a. REC'D BY REGISTRAR DATE <i>DEC 4 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>															

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1453

1453



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14776

CERTIFICATE OF DEATH

16292

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>-</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. LENGTH OF STAY IN lb <u>12 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>		d. STREET ADDRESS <u>16 Market Place</u>	
3. NAME OF DECEASED (Type or print) <u>Edward W. Atkins</u>		4. DATE OF DEATH Month <u>11</u> Day <u>29</u> Year <u>19 67</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>3-6-1899</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>29</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Georgetown Delaware</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Allen Atkins</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Wilson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>229-05-1783</u>	
17. INFORMANT <u>Hospital Records, Crownsville, Maryland</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Insufficiency; Pneumonitis</u> DUE TO (b) <u>Pulmonary Emphysema</u> DUE TO (c) <u>Alcoholism, Chronic</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Alcoholism, Chronic</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11/17</u> , 19 <u>67</u> , to <u>11/29</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11/29/1967</u> , and that death occurred at <u>3:00M</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>L. Benedict, M.D.</u>		22b. DATE SIGNED <u>11/29/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>L. Benedict, M.D.</u>		22d. ADDRESS <u>Crownsville State Hospital, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>12-20-67</u>	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <u>Wm. Reese Funeral Home</u>		25a. REC'D BY REGISTRAR <u>DEC 22 1967</u>	
ADDRESS <u>108 W. Washington Ave</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Yuaga</u>	

10000

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10000



CERTIFICATE OF DEATH

14773

14784

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 8 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 227 N. Spring Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Johnny Barnes		4. DATE OF DEATH Month 11 Day 7 Year 1967	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/15/23
9. AGE (In years lost birthday) 44 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown	
11. BIRTHPLACE (County & State, or foreign country) Richmond Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Barnes		14. MOTHER'S MAIDEN NAME Molly Hines	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Hospital Records, Crownsville, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Insufficiency Cirrhosis of liver DUE TO (b) Chronic alcoholism DUE TO (c) 5811 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchopneumonia; anemia; peripheral neuropathy			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 10/30/ , 19 67 , to 11/7/ , 1967, that (I) (we) last saw the deceased alive on 11/7/ , 19 67 , and that death occurred at 10:00 from causes and on the date stated above.			
22a. SIGNATURE <i>[Signature]</i>		22b. DATE SIGNED 11/8/67	
22c. PHYSICIAN'S NAME (Type) Ludwig Benedict, M.D.		22d. ADDRESS Crownsville State Hospital, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF Nov 20, 1967	23c. NAME OF CEMETERY OR CREMATORY Not Calvary Cemetery	23d. LOCATION (City or town) (County) (State) Brooklyn Md
24. FUNERAL DIRECTOR Joseph H. Rivas		25a. REC'D BY REGISTRAR 2222 N. North Ave. Baltimore, Md	
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		DATE NOV 22 1967	

CERTIFICATE OF DEATH

14778

14785

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Severn c. LENGTH OF STAY IN TB Downey Road d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Downey Road				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Severn d. STREET ADDRESS Downey Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Francis Cornelius Beatty		4. DATE OF DEATH Month 11 Day 29 Year 1967					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/27/1914	9. AGE (In years last birthday) 53 yrs.	10. IF UNDER 1 YEAR Months 11 Days 29		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Iron Worker		10b. KIND OF BUSINESS OR INDUSTRY Structural		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland			
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Adam Beatty			14. MOTHER'S MAIDEN NAME Flannigan				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No.		16. SOCIAL SECURITY NO. 215-03-3025		17. INFORMANT Jerome Beatty Address Downey Road			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic failure Conditions, if any, which gave rise to immediate cause (b) metastatic carcinoma (c) primary in pancreas PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 1578					INTERVAL BETWEEN ONSET AND DEATH 8 weeks 6 mos.		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 4/15	20g. (County) 1966	20h. (State) 8/15		
21. I certify that (I) (this hospital) attended the deceased from 4/15 , 1966 to 8/15 , 1967, that (I) (we) last saw the deceased alive on 8/15 , 1967, and that death occurred at 12:00 AM , from the causes and on the date stated above.							
22a. SIGNATURE Robert C. Duvall		22b. DATE SIGNED 11/29/67					
22c. PHYSICIAN'S NAME (Type) Robert C. Duvall, M. D.		22d. ADDRESS 701 St. Paul St. - Balto., Md. 21202					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/1/67	23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Park	23d. LOCATION (City, town or county) Howard County, Md.				
24. FUNERAL DIRECTOR'S SIGNATURE Raymond C. Fink		25a. REC'D BY REGISTRAR Glen Burnie, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge			

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14773

14773

RECEIVED

TO THE DIRECTOR OF THE BUREAU OF REVENUE
FROM THE COMMISSIONER OF THE GENERAL LAND OFFICE
SUBJECT: [Illegible]
[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a formal letter or report containing several paragraphs of text, possibly discussing land matters or revenue collection. Key words like "BUREAU OF REVENUE" and "GENERAL LAND OFFICE" are visible in the header and footer areas.]

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 PLACE OF DEATH a COUNTY <u>ANNE ARUNDEL</u> MARYLAND						2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Anne Arundel</u>					
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>				c LENGTH OF STAY IN 1b		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>					
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ANNAPOLIS CONVALESCENT HOME</u>						d STREET ADDRESS <u>680 Americana Dr.</u>				e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Emma Marie Becnot</u>						4 DATE OF DEATH Month <u>11</u> Day <u>14</u> Year <u>1967</u>					
5 SEX <u>F</u>		6 COLOR OR RACE <u>W</u>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>8-7-1878</u>		9 AGE (In years last birthday) <u>89</u> yrs		IF UNDER 1 YEAR Months <u>11</u> Days <u>14</u> Hours <u>19</u> Min <u>67</u>	
10a USUAL OCCUPATION (Give kind at work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11 BIRTHPLACE (County & State, or foreign country) <u>PROVISO, ILL.</u>				12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13 FATHER'S NAME <u>August BATHE</u>						14 MOTHER'S MAIDEN NAME <u>Sophia AHRENS</u>					
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>				16 SOCIAL SECURITY NO <u>—</u>		17 INFORMANT <u>Theodore W. Hoxhold</u>				Address # <u>2</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gran - re schenmi</u> DUE TO (b) <u>pyelonephritis (uro)</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Cerebral thrombosis</u>											
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)							
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>				20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>1/7/1967</u> to <u>11/14/1967</u> , that (I) (we) last saw the deceased alive on <u>11/12/1967</u> , and that death occurred at <u>10:30 a.m.</u> from causes and on the date stated above											
22a SIGNATURE <u>Gerard Blucher</u>						M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b DATE SIGNED <u>11/14/67</u>			
22c PHYSICIAN'S NAME (Type) <u>Gerard Blucher</u>						22d ADDRESS <u>121 Cathedral St, Annapolis Md</u>					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE THEREOF		23c NAME OF CEMETERY OR CREMATORY				23d LOCATION (City or Town) (County) (State)			
<u>BURIAL</u>		<u>11-16-67</u>		<u>PROVISO</u>				<u>WEST CHESTER ILL.</u>			
24 FUNERAL DIRECTOR <u>John M. Taylor San Annapolis Md</u>						25a REC'D BY REGISTRAR <u>NOV 15 1967</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14787

1 PLACE OF DEATH a COUNTY <u>Worcester</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Worcester</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c LENGTH OF STAY in lb <u>13 months</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>		d STREET ADDRESS <u>304 Hammond's Ferry Rd</u>	
3 NAME OF DECEASED (Type or print) <u>Colia K. Bextel</u>		4 DATE OF DEATH Month <u>11</u> Day <u>18</u> Year <u>1967</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>12-6-92</u>
9 AGE (In years last birthday) <u>74</u> yrs		10 IF UNDER 1 YEAR Months <u>11</u> Days <u>18</u> Hours <u>19</u> Min <u>67</u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic (Ret)</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Kitchen Employee</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Klymn, Wisconsin</u>		12 CIT ZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Wenzel Kreuziger</u>		14 MOTHER'S MAIDEN NAME <u>(unknown)</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>391-20-1238A</u>	
17 INFORMANT <u>MR. Lawrence Bextel (son)</u>		Address <u>Same as #2</u>	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Ulcera</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>dehydration</u>			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10-10</u> , 19 <u>66</u> , to <u>11-18-67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11-18</u> , 19 <u>67</u> , and that death occurred at <u>9:30 AM</u> , from causes and on the date stated above			
22a. SIGNATURE <u>Carl A. Phillips MD</u>		22b. DATE SIGNED <u>11-18-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ERRICA-PHILLIPS-MD</u>		22d. ADDRESS <u>Crownsville State Hospital</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>Nov 21, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Henry's Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Water Town, W.V.</u>
24 FUNERAL DIRECTOR <u>E. B. Fleming</u>		25a. REC'D BY REGISTRAR <u>NOV 21 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14781

CERTIFICATE OF DEATH

14788

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Calvert	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN TB Sunderland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS Sunderland	
3. NAME OF DECEASED (Type or print) George First Middle Last Pembroke BLAKE		4. DATE OF DEATH Month Day Year November 13 19 67	
5 SEX Male	6. COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH November 19, 1913
9. AGE (In years lost birthday) 53 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11 BIRTHPLACE (County & State, or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Thomas H. Blake		14. MOTHER'S MAIDEN NAME Josephine Pembroke	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 216-18-5309	
17. INFORMANT Mrs. Mary Blake, Sunderland, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Massive pulmonary edema 307X DUE TO asphyxiated vomitus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Delirium tremens DUE TO chronic alcoholism (c)		INTERVAL BETWEEN ONSET AND DEATH Immediate 3-4 days	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 11-9 , 19 67 , to 11-13 , 19 67 , that (I) (we) last saw the deceased alive on 11-13 , 19 67 , and that death occurred at 7:30 P.M. from causes not on the date stated above			
22a. SIGNATURE Richard F. Maschell		22b. DATE SIGNED 11-14-67	
22c. PHYSICIAN'S NAME (Type) Richard F. Maschell		22d. ADDRESS Annapolis, Maryland	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Nov. 16, 1967	23c. NAME OF CEMETERY OR CREMATORY All Saints Chr. Cemetery	23d. LOCATION (City or Town) (County) (State) Sunderland Calvert Md.
24 FUNERAL DIRECTOR Hutchins Funeral Home Owings, Md.		25a. REC'D BY REGISTRAR DATE NOV 16 1967	25b. REGISTRAR'S SIGNATURE Charles Judge



14782

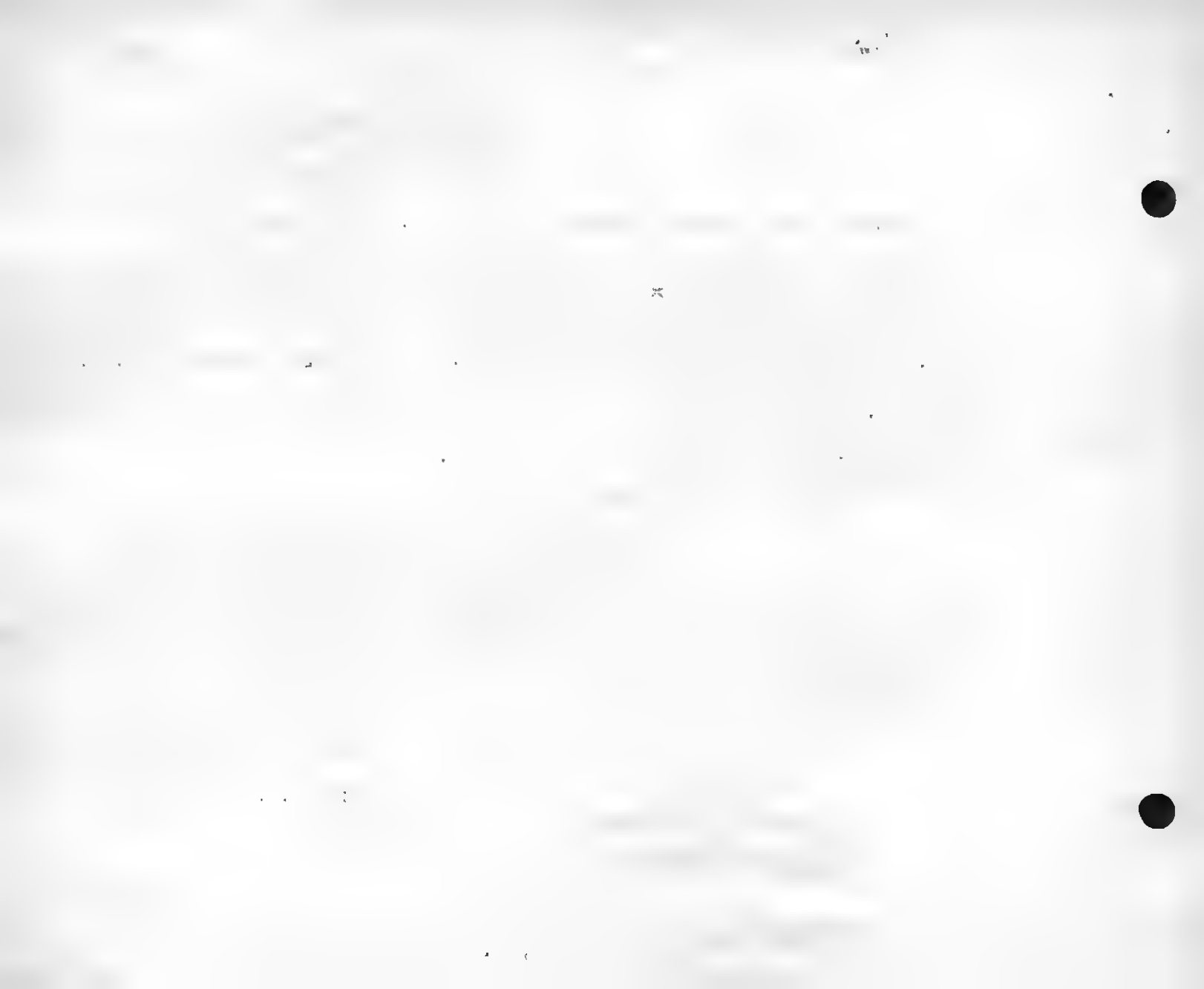
CERTIFICATE OF DEATH

14789

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN TB	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		e. STREET ADDRESS Rt. 3, Box 538	
3. NAME OF DECEASED (Type or print) Ralph		4. DATE OF DEATH Month November Day 23 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 6, 1913
9. AGE (In years last birthday) 54 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Foreman		10b. KIND OF BUSINESS OR INDUSTRY Carr-Lowrey-Glass Co.	
11. BIRTHPLACE (County & State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Henry R. Blankenship		14. MOTHER'S MAIDEN NAME Shara Riffe	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 233-12-1489	
17. INFORMANT Mona B. Blankenship - Same as # 2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphosarcoma 2001 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 11/23 , 19 67 , to Nov , 19 67 , that (I) (we) last saw the deceased alive on 11/23 , 19 67 , and that death occurred at 9:15 P.M. from causes and on the date stated above			
22a. SIGNATURE Robert O. Brien		22b. DATE SIGNED 11/24	
22c. PHYSICIAN'S NAME (Type) Robert Brien M.D.		22d. ADDRESS Annapolis Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/27/67	23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Pk	23d. LOCATION (City or Town) (County) (State) Glen Burnie, Maryland
24. FUNERAL DIRECTOR Singleton Funeral Home		25a. REC'D BY REGISTRAR NOV 27 1967	
ADDRESS Glen Burnie, Md.		25b. REGISTRAR'S SIGNATURE Thomas Judge	



CERTIFICATE OF DEATH

14783

14790

1 PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALT. CITY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FT. GEO. G. MEADE.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CURTIS BAY Baltimore, 26	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) KIMBROUGH ARMY HOSPITAL		d. STREET ADDRESS 4800 CURTIS AVE.	
3 NAME OF DECEASED (Type or print) PAULINE BURLETT BLOOM		4 DATE OF DEATH Month NOVEMBER Day 23 Year 19 67	
5. SEX FEMALE	6. COLOR OR RACE CAU	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 22 APRIL 1900
9. AGE (In years last birthday) yrs. 67		10. IF UNDER 1 YEAR Months Days Hours Mm. 20 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE & Owner		10b. KIND OF BUSINESS OR INDUSTRY Self-Employed	
11. BIRTHPLACE (County & State, or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME (unknown) KESSLER		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO one		16. SOCIAL SECURITY NO Unknown	
17. INFORMANT (Husband) JOHN BLOOM		Address 4800 CURTIS AVE, CURTIS BAY	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DIABETES MELLITUS DUE TO (b) KIMMELSTIEL WILSON DISEASE DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 1 yr.
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (husband) attended the deceased from 16 November 19 67 , to 23 November 19 67 that (I) (husband) last saw the deceased alive on 22 November 19 67 , and that death occurred at 1220 AM , from causes and on the date stated above			
22a. SIGNATURE <i>Lynn W. Holder</i>		22b. DATE SIGNED 23 Nov 67	
22c. PHYSICIAN'S NAME (Type) LYNN W. HOLDER, CPT, MC		22d. ADDRESS KIMBROUGH ARMY HOSPITAL	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF Nov. 25, 67	23c. NAME OF CEMETERY OR CREMATORY GLENHAVEN Memorial Pk	23d. LOCATION (City or Town) (County) (State) GLENBURNIE, MD.
24. FUNERAL DIRECTOR <i>E. B. Fleming</i>		25a. REC'D BY REGISTRAR DATE NOV 27 1967	
ADDRESS Singleton Funeral Home Glen Burnie, Maryland		25b. REGISTRAR'S SIGNATURE <i>J. J. Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

14784

14791

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLEN BURNIE c. LENGTH OF STAY IN 1b 10 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) NORTH ARUNDEL CONVALESCENT CENTER		2. USUAL RESIDENCE (Where deceased lived, if not institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLEN BURNIE d. STREET ADDRESS 1305 CORY DRIVE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) STEPHEN First Middle Last BOBENKO		4. DATE OF DEATH Month Day Year NOVEMBER 19 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 1, 1892
9. AGE (in years last birthday) 75		10. UNDER 1 YEAR Months Days Hours Min	11. UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Lavern	
11. BIRTHPLACE (County & State, or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Aleksey Bobenko		14. MOTHER'S MAIDEN NAME Tatiana Katanko	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NO	
17. INFORMANT Mrs. Anna Bobenko		Address 1305 Cory Drive	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY 443X IMMEDIATE CAUSE (a) Cerebro-Vascular accident DUE TO (b) Hypertensive Cardiovascular disease DUE TO (c) Hypertensive Cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Oct 20 , 19 67 , to Nov. 19 , 19 67 , that (I) (we) last saw the deceased alive on Nov 18 , 19 67 , and that death occurred at 4:30 A.M. , from causes on and the date stated above			
22a. SIGNATURE Joseph Taler, M.D.		22b. DATE SIGNED 11/20/67	
22c. PHYSICIAN'S NAME (Type) JOSEPH TALER, M.D.		22d. ADDRESS 95 Apurhart Rd. Glen Burnie Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 11 21 1967	23c. NAME OF CEMETERY OR CREMATORY St. Andrews	23d. LOCATION (City or Town) (County) (State) German Hill Rd. etc. Md.
24. FUNERAL DIRECTOR J. C. Gully		25a. REC'D BY REGISTRAR NOV 21 1967	
25b. REGISTRAR'S SIGNATURE J. C. Gully			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14785

CERTIFICATE OF DEATH

14792

1. PLACE OF DEATH a COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>MARYLAND</u> b COUNTY <u>ANNE ARUNDEL</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GLEN BURNIE</u>		c LENGTH OF STAY IN 1b <u>1 1/2 mo.</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>NORTH ARUNDEL CONV. CENTER</u>		d STREET ADDRESS <u>660 AMERICAN DRIVE</u>	
3 NAME OF DECEASED (Type or print) <u>GEORGE H. BORCHERDING</u>		4 DATE OF DEATH <u>November 13 1967</u>	
5 SEX <u>MALE</u>	6 COLOR OR RACE <u>CAUC.</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>August 19, 1889</u>
9 AGE (in years last birthday) <u>78</u> yrs		F UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>POLICEMAN</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Balto. City</u>	
11 BIRTHPLACE (County & State or foreign country) <u>BALTIMORE</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Charles Borcharding</u>		14 MOTHER'S MAIDEN NAME <u>Catherine Lehman</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of serv ce)		16 SOCIAL SECURITY NO. <u>WM H. Borcharding</u>	
17 INFORMANT <u>WM H. Borcharding</u>		Address <u>#2</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Malabsorption Syndrome</u> DUE TO <u>Left Ventricular failure</u> (b) <u>Gross hematuria</u> (c) <u>Gross hematuria</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Months</u> <u>hours</u> <u>days</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis</u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR. B.T.G. <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 25, 1967</u> to <u>Nov 13, 1967</u> , that (I) (we) last saw the deceased alive on <u>Nov 13, 1967</u> , and that death occurred at <u>8:45 PM</u> from causes and on the date stated above		20f (City or town) (County) (State)
22a. SIGNATURE <u>Max C Frank</u>	M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b DATE SIGNED <u>11/13/67</u>
22c. PHYSICIAN'S NAME (Type) <u>MAX C FRANK</u>	22d. ADDRESS <u>425 SE Ritchie Hwy Glen Burnie Md 21061</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b DATE THEREOF <u>11-16-67</u>	23c NAME OF CEMETERY OR CREMATORY <u>CHESTERFIELD</u>
23d LOCATION (City or Town) (County) (State) <u>CENTERVILLE MD.</u>		24 FUNERAL DIRECTOR <u>John M. Latoras Annapolis, Md.</u>
25a REC'D BY REGISTRAR <u>NOV 15 1967</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

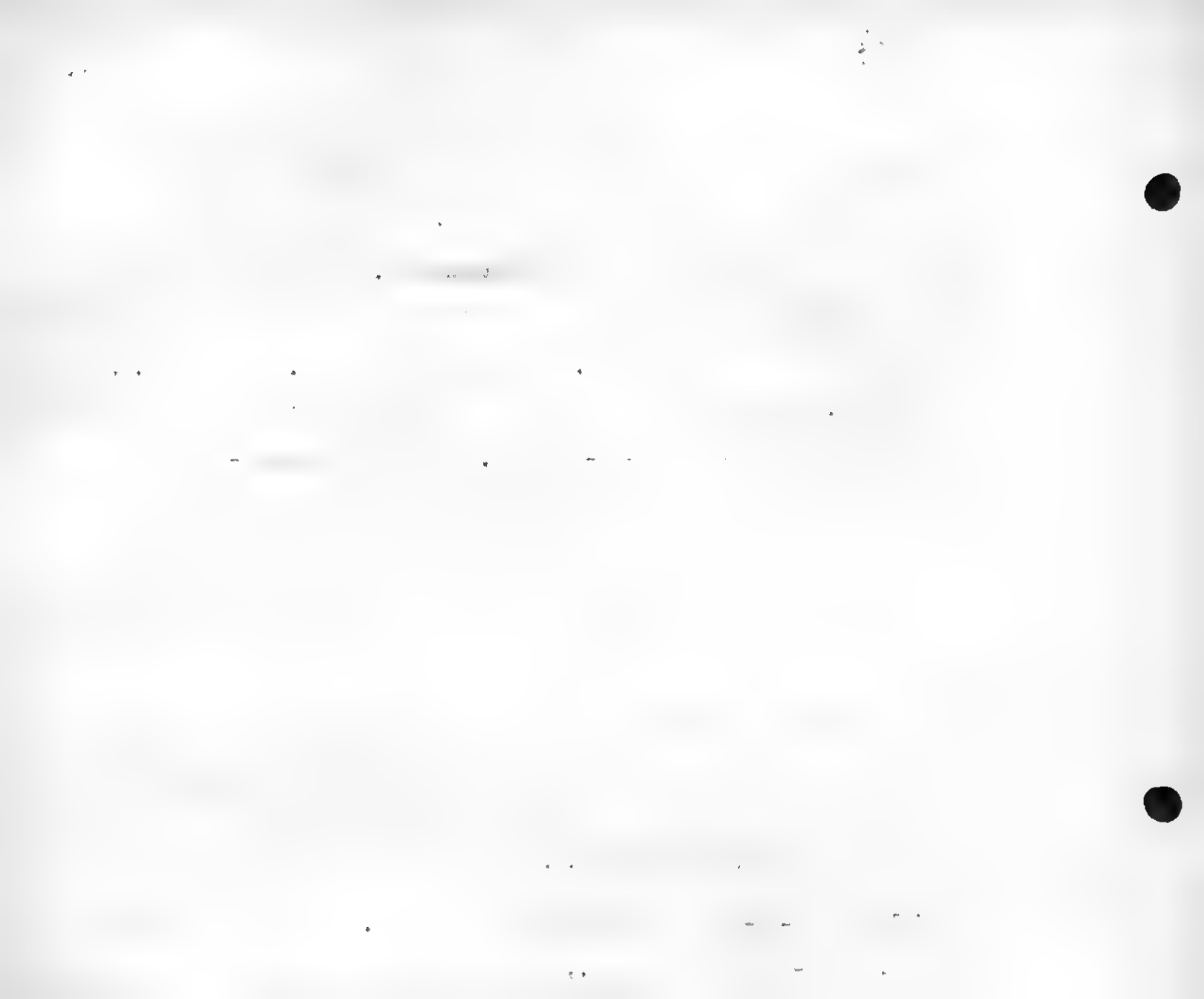
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14786

14793

1 PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN lb Pasadena	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital		d. STREET ADDRESS Rt. 3 - Box 85	
3 NAME OF DECEASED (Type or print) TRUMAN A BRITTINGHAM Jr.		4 DATE OF DEATH Month November Day 26 Year 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-30-28
9 AGE (In years lost birthday) yrs 39		10a. OCCUPATION (Give kind of work done during most of working life, even if retired) Driver	
10b. KIND OF BUSINESS OR INDUSTRY Bus Co.		11 BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Truman A. Brittingham	
14. MOTHER'S MAIDEN NAME Thelma Lopez		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes 1-26-55/9-28-60	
16 SOCIAL SECURITY NO 215-24-5095		17 INFORMANT Mrs. Truman Brittingham - same	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic heart disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate EXAMINER'S NAME (Type) Charles S. Springate, M.D.		22. DATE SIGNED November 26, 1967	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-29-1967	
23c. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial Pk.		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24 FUNERAL DIRECTOR George J. Gonce-4001 Ritchie Hwy., Baltimore		25a. REC'D BY REGISTRAR DEC 4 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



CERTIFICATE OF DEATH

14794

14787

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>APLE BRUNDEL</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linthicum</u>		c. LENGTH OF STAY IN 1b <u>Linthicum</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>109 SYCAMORE RD</u>		d. STREET ADDRESS <u>109 SYCAMORE RD</u>	
3 NAME OF DECEASED (Type or print) <u>RICHARD H. BROWN</u>		4 DATE OF DEATH Month <u>NOV</u> Day <u>1</u> Year <u>1967</u>	
5 SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>9-31-1894</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TELEPHONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cap. Tel. Co.</u>	9 AGE (In years last birthday) yrs <u>72</u>
11 BIRTHPLACE (County & State, or foreign country) <u>Annapolis MD.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JOHN M. BROWN</u>		14. MOTHER'S MARDEN NAME <u>HOUSE HAMBROCK</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>YES U.S.N.</u>		16 SOCIAL SECURITY NO. <u>MAE BROWN HOOPER #2</u>	
17 INFORMANT <u>MAE BROWN HOOPER #2</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>443X</u> IMMEDIATE CAUSE (a) <u>Cardio-Vascular Disease</u> DUE TO (b) <u>Hypertension</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>4 wks</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o.m.</u> <u>19</u> p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1935</u> to <u>11/1</u> , 1967, that (I) (we) last saw the deceased alive on <u>11/1/67</u> <u>1967</u> and that death occurred at <u>11 P</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>Charles L. Ball Jr</u> MD		22b. DATE SIGNED <u>11/10/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>C. L. BALL Jr</u>		22d. ADDRESS <u>Linthicum Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>11-5-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR Bluff</u>	23d. LOCATION (City or town) (County) (State) <u>ANNAPOLIS A.P. MD.</u>
24. FUNERAL DIRECTOR <u>John M. Gay & Sons Annapolis, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 6 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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VR A15 (1-6)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 3 years 5 mon.		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland		b. COUNTY Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21206	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital						d. STREET ADDRESS 5403 Seward Avenue					
3. NAME OF DECEASED (Type or print) First Middle Last Irene G. Burch						4. DATE OF DEATH Month Day Year 11 6 1967					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/29/83		9. AGE (In years last birthday) 84 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Gonzaga Burch						14. MOTHER'S MAIDEN NAME Irene Gardiner					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Address Hospital Records, Crownsville, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia right lung DUE TO (b) arteriosclerotic cardio-vascular disease DUE TO (c) Chronic Brain Syndrome											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Brain Syndrome											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from 6/19/1964 , to 11/6/1967 , that (I) (we) last saw the deceased alive on 11/6/1967 , and that death occurred at 8:15 M. from causes and on the date stated above.											
22a. SIGNATURE L. Bendict						22d. ADDRESS Crownsville State Hospital, Maryland		22b. DATE SIGNED 11/7/67		22c. PHYSICIAN'S NAME (Type) L. Bendict	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/10/67.		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery				23d. LOCATION (City or Town) (County) (State) Baltimore, Md.			
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214						25a. REC'D BY REGISTRAR NOV 9 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14789

14796

1 PLACE OF DEATH o COUNTY <u>Anne Arundel</u> o STATE <u>MARYLAND</u>		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) o STATE <u>Maryland</u> b CITY <u>Anne Arundel</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Near Annapolis</u>		c LENGTH OF STAY IN 1b <u>Arnold</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DOA Anne Arundel General</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF <u>Leslie</u> <u>Ann</u> <u>Burnett</u> (Type or print)		4 DATE OF DEATH Month <u>Nov</u> Day <u>13</u> Year <u>1967</u>	
5 SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>12-9-1946</u>
9 AGE (In years last birthday) yrs <u>20</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life. Even if retired) <u>Student</u>	
11 BIRTHPLACE (State or foreign country) <u>Colorado</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jack G. Burnett</u>		14 MOTHER'S MAIDEN NAME <u>Norma CASTEEL</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Jack G. Burnett</u>	
17. INFORMANT <u>Jack G. Burnett</u>		Address <u>#2</u>	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>multiple injuries</u> DUE TO (b) <u>gun</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>gun</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Aut drunk found</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Aut drunk found</u>	
20c. TIME OF INJURY Month, Day, Year <u>11/13 1967</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> <u>Highway</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.)		20f. (City or town) (County) (State) <u>Annapolis</u> <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from <u>Natural causes</u> <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>[Signature]</u> M.D.		22. DATE SIGNED <u>11-13-67</u>	
EXAMINER'S NAME (Type) <u>F. Linhardt</u>		Address (Street, city, town, or county) <u>Annapolis, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>11-15-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST. ANNE'S</u>	23d. LOCATION (City or Town) (County) (State) <u>Annapolis MD.</u>
24. FUNERAL DIRECTOR <u>John M. Taylor</u>		25a. REC'D BY REGISTRAR <u>NOV 15 1967</u>	
Address <u>Annapolis, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14790

14797

1 PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SEVERNA PARK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park Md</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6 Riggs ROAD</u>		e. STREET ADDRESS <u>6 Riggs Rd.</u>	
3 NAME OF DECEASED (Type or print) <u>Elliott Hall Burwell</u>		4 DATE OF DEATH <u>11-11-67</u>	
5 SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Jan 25, 1883</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Anne Arundel Co. Md.</u>
13 FATHER'S NAME <u>Elliott H. Burwell</u>		14. MOTHER'S MAIDEN NAME <u>Augusta S. Sellers</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes</u>		16 SOCIAL SECURITY NO	
17 INFORMANT <u>BERTHA B. BURWELL #2</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO (b) <u>C.E.U.D.</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1960</u> , 19 to <u>1967</u> , 19, that (I) (we) last saw the deceased alive on <u>11-11-67</u> , 19, and that death occurred at <u>7:10 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Robert R. Hahn</u> M.D.		22b. DATE SIGNED <u>11-11-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert R. HAHN</u>		22d. ADDRESS <u>P.O. Box 13 Severna Park</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>11-14-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Christ Church</u>	23d. LOCATION (City or Town) (County) (State) <u>OWENSVILLE MD.</u>
24 FUNERAL DIRECTOR <u>John M. Taylor Sons Company, Md.</u>		25a. REC'D BY REGISTRAR <u>NOV 15 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14789

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>Al. Al.</u> MARYLAND		2 USUAL RESIDENCE (where deceased lived, if institution: Residence before admission) a STATE <u>Al.</u> b COUNTY <u>Al.</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c LENGTH OF STAY IN 1b	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. Al. General</u>		e STREET ADDRESS <u>Little Road</u>	
3 NAME OF DECEASED (Type or print) <u>William Butler</u>		4 DATE OF DEATH Month <u>11</u> Day <u>21</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>Col.</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>7-14-1907</u>
9 AGE (In years lost birthday) yrs <u>60</u>		10 IF UNDER 1 YEAR Months <u>11</u> Days <u>21</u>	
10b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10c KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <u>Al.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Eddie Butler</u>		14 MOTHER'S MAIDEN NAME <u>Hattie Harker</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>577-285356</u>	
17 INFORMANT <u>Lillie Butler Bister</u>		Address <u>Al.</u>	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Injuries</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <u>None</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Auto - accident - walking on highway</u>	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>	20f (City or town) (County) (State) <u>Al.</u> <u>MD</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. L. in hand</u>		22. DATE SIGNED <u>11-21-67</u>	
EXAMINER'S NAME (Type) <u>E. L. in hand</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>11-25-67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Onionsville</u>	23d LOCATION (City or Town) (County) (State) <u>Onionsville Al.</u>
24 FUNERAL DIRECTOR <u>William Reese</u>		25a REC'D BY REGISTRAR <u>NOV 22 1967</u>	
ADDRESS <u>Al.</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14792.

14800

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if not institution. Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 160 Prince George Street	
3. NAME OF DECEASED (Type or print) First Charlotte Middle Whaley Last CLAUDE		4. DATE OF DEATH Month November Day 17 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 30, 1897
9. AGE (In years last birthday) yrs 69		10. F. UNDER 1 YEAR Months 1 Days 1 IF UNDER 24 HRS Hours 1 Min 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (County & State or foreign country) DAYTON, Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME WM WHALEY		14. MOTHER'S MAIDEN NAME GRACE VANDERHORST	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO —	
17. INFORMANT W. CLEMENT CLAUDE #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Essentially DUE TO (b) Cardiac arrest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) long years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) physician attended the deceased from Nov. 17, 1967 , that (I) physician last saw the deceased alive on Nov. 17, 1967 , and that death occurred at 6:45 PM , from causes and on the date stated above.			
22a. SIGNATURE Stephen B. Hiltabidle M.D.		22b. DATE SIGNED 11-18-67	
22c. PHYSICIAN'S NAME (Type) Stephen B. Hiltabidle, M.D.		22d. ADDRESS 121 Cathedral Street, Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL, etc. BURIAL	23b. DATE THEREOF 11-20-67	23c. NAME OF CEMETERY OR CREMATORY ST. ANNE'S	23d. LOCATION (City or Town) (County) (State) ANNAPOOLIS MD.
24. FUNERAL DIRECTOR John M. Long		25a. REC'D BY REGISTRAR NOV 21 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

14793

CERTIFICATE OF DEATH

14001

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN lb 3 years		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital				d. STREET ADDRESS 52 W. Washington St.	
3. NAME OF DECEASED (Type or print) Charles Franklin COLE		4. DATE OF DEATH Month November Day 4 Year 1967		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 10, 1907	9. AGE (In years last birthday) 60 yrs	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffuer		10b. KIND OF BUSINESS OR INDUSTRY *****		11. BIRTHPLACE (County & State, or foreign country) A.A.Co Md	
13. FATHER'S NAME Thomas Cole		14. MOTHER'S MAIDEN NAME Mary Anderson		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No *****		16. SOCIAL SECURITY NO 214-05-2120		17. INFORMANT Mary A. Butler 1184 President st	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Atherosclerosis DUE TO (b) Liver Disease DUE TO (c) C.V.D.					INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19__	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 11-3-67 , 19__, to 11-4-67 , 19__, that (I) (we) last saw the deceased alive on 11-4-67 , 19__, and that death occurred at 6:30 A.M. from causes and on the date stated above.					
22a. SIGNATURE Robert R. Hahn		22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) ROBERT R. HAHN, MD	
22d. ADDRESS Severna Park, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11-7-67	23c. NAME OF CEMETERY OR CREMATORY Brewer Hill	23d. LOCATION (City or Town) (County) (State) Annapolis A.A.Co Md		
24. FUNERAL DIRECTOR C. E. Hicks, 111 Annapolis, Md		25a. REC'D BY REGISTRAR NOV 9 1967	25b. REGISTRAR'S SIGNATURE Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and in any event, within 72 hours after death, should be filed with the State Dept of Health prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14794

CERTIFICATE OF DEATH

14802

1 PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS, MD.			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SHADYSIDE		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) NAVAL HOSPITAL				d. STREET ADDRESS CHESTNUT ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BABY GIRL COLLINS				4. DATE OF DEATH Month Nov Day 12 Year 1967			
5. SEX FEMALE		6. COLOR OR RACE CAUC		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12 Nov. 1967	
9. AGE (In years last birthday) yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) yrs	
11. BIRTHPLACE (County & State, or foreign country) Annapolis, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME DENNIS COLLINS		14. MOTHER'S MAIDEN NAME LILLY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT DENNIS COLLINS #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Distress</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Prematurity</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 13 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS A. TOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 0537 12 Nov. 1967, to 12 Nov. 1967 that (I) (we) just saw the deceased alive on 12 Nov. 1967, and that death occurred at 1840 M, from causes and on the date stated above.							
22a. SIGNATURE Bill R. Fulk				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 12 Nov. 1967	
22c. PHYSICIAN'S NAME (Type) BILL R. FULK, LT MC USN				22d. ADDRESS NAVAL HOSPITAL, ANNAPOLIS, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11-13-67		23c. NAME OF CEMETERY OR CREMATORY U.S. NAVAL CEMT.		23d. LOCATION (City or Town) (County) (State) Annapolis MD.	
24. FUNERAL DIRECTOR JOHN M. TAYLOR & SONS, ANNAPOLIS, MD.				25a. REC'D BY REGISTRAR NOV 15 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 - and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14795

CERTIFICATE OF DEATH

14003

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Dora Lee Cheeks Cooper		4 DATE OF DEATH Month Day Year 11 25 19 67	
5 SEX F	6. COLOR OR RACE Negro	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 9/6/24
9. AGE (in years last birthday) 43 yrs		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Presser		10b. KIND OF BUSINESS OR INDUSTRY Cleaner	
11 BIRTHPLACE (County & State, or foreign country) South Hill, Virginia		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Landon Cheeks Sr.		14. MOTHER'S MAIDEN NAME Willie Jane Reid	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Hospital Records, Crownsville, Maryland		Address	
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic Alcoholism DUE TO 3221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Brain Syndrome; Malnutrition'			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour am pm 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from 4/19/1966, to 11/25/1967 that (I) (we) last saw the deceased alive on 11/25/1967, and that death occurred at 6:00 PM, from causes and on the date stated above.			
22a. SIGNATURE Ludwig Benedict, M.D.		22b. DATE SIGNED 11/27/67	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS Crownsville State Hospital, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/1/67	23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland
24 FUNERAL DIRECTOR Herbert E. Nutter-3035 W. North Ave.		25a. REC'D BY REGISTRAR DATE DEC 1 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

1

2



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14796

14804

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>M.A. Co</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE <u>MD</u> b COUNTY <u>HACO</u>			
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Glen Burnie.</u>		c LENGTH OF STAY IN 1b <u>D.O.A.</u>		c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Glen Burnie.</u>		c 2-1	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Narundel - Hospital</u>				d STREET ADDRESS <u>124 North Ocean Hgh.</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>CORTINA</u> Last <u>CORTINA</u>				4 DATE OF DEATH Month <u>11</u> Day <u>12</u> Year <u>1967</u>			
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>2/5/99</u>		9 AGE (in years last birthday) <u>68</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days
10a USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>(Ret)</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Shoe Store (Repair)</u>		11 BIRTHPLACE (State or foreign country) <u>Pollina Sicily</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13 FATHER'S NAME <u>August Cortina</u>				14 MOTHER'S MAIDEN NAME <u>SANTINA (UNKNOWN)</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16 SOCIAL SECURITY NO <u>219-32-3519A</u>		17 INFORMANT Address <u>Antoinette McCauley - (Daughter)</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio Sclerosis generalized</u> <u>4500</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u> sudden</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of Item 18)					
20c TIME OF INJURY Month Day, Year Hour a.m. _____ p.m. <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f City town _____ County _____ (State) _____	
21. I certify that I took charge of the remains described above held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>E. Linhardt</u> M.D. EXAMINER'S NAME (Type) <u>E. Linhardt</u>				22. DATE SIGNED <u>11-12-67</u>			
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>11/15/1967</u>		23c NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial Pk.</u>		23d LOCATION (City, town, county, state) <u>Glen Burnie</u>	
24 FUNERAL DIRECTOR <u>Robert P. Ware</u> <u>Singleton Funeral Home - Glen Burnie, Md.</u>				25a REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>NOV 14 1967</u>			



14797

CERTIFICATE OF DEATH

14885

1 PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>AI</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. LENGTH OF STAY IN 1b <u>19 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>		d. STREET ADDRESS <u>406 Morris Hill Avenue</u>	
3 NAME OF DECEASED (Type or print) <u>Wilton Henry Crawley</u>		4 DATE OF DEATH Month <u>11</u> Day <u>5</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/19/00</u>
9. AGE (in years last birthday) <u>67</u> yrs		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>19</u> Hours <u>67</u> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Musician</u>		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Crawley</u>		14. MOTHER'S MAIDEN NAME <u>Katy Drew</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>unknown</u>	
17. INFORMANT <u>Hospital Records, Crownsville, Maryland</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>443X</u> IMMEDIATE CAUSE (a) <u>Uremia Chronic renal failure; Acute pyelonephritis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive cardio vascular disease</u> DUE TO (c) -----			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Chronic Brain Syndrome</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10/17</u> , 1967, to <u>11/5</u> , 1967, that (I) (we) last saw the deceased alive on <u>11/5</u> , 1967, and that death occurred at <u>7:55</u> M, from causes and on the date stated above.			
22a. SIGNATURE <i>L. Benedict</i>		22b. DATE SIGNED <u>11/6/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>L. Benedict, M.D.</u>		22d. ADDRESS <u>Crownsville State Hospital, Maryland</u>	
23a. BURIAL, CREMATION, REMOVA. (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 7, 67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>Charles R. Law, 802 Madison Ave.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 9 1967</u>	
		25b. REGISTRAR'S SIGNATURE <i>Ray Jones</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



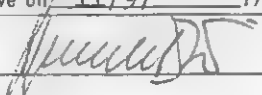

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11799

CERTIFICATE OF DEATH

14806

1. PLACE OF DEATH a. COUNTY Anne Arundel <div style="text-align: right;">MARYLAND</div>		2. USUAL RESIDENCE (Where deceased lived, if institution or Residence before admission) a. STATE Maryland b. COUNTY 17A	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 22 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital		e. STREET ADDRESS 21 Ferndale Ave.	
3. NAME OF DECEASED (Type or print) First Edith Middle H. Last Crum		4. DATE OF DEATH Month 11 Day 9 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/11/84
9. AGE (In years last birthday) 83 yrs		F UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS Months Days Hours Min	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (County & State, or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Hawes		14. MOTHER'S MAIDEN NAME Lily Townsend	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 232-28-2101 A	
17. INFORMANT Hospital Records, Crownsville, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute coronary Insufficiency DUE TO Arteriosclerotic Cardio vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Brain Syndrome			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 10/18 , 19 67 , to 11/9 , 19 67 , that (I) (we) lost saw the deceased alive on 11/9/ 19 67 , and that death occurred at 8:30 a.m. from causes and on the date stated above.			
22a. SIGNATURE 		22b. DATE SIGNED 11/9/67	
22c. PHYSICIAN'S NAME (Type) L. Benedict, M.D.		22d. ADDRESS Crownsville, State Hospital, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11 Nov. 67	23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Park	23d. LOCATION (City or Town) (County) (State) Glen Burnie, Md.
24. FUNERAL DIRECTOR Winkley Funeral Home, Glen Burnie, Md.		25a. REC'D BY REGISTRAR DATE NOV 13 1967	
25b. REGISTRAR'S SIGNATURE 			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed on by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14799

CERTIFICATE OF DEATH

14867

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE b. COUNTY Washington, D. C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		c. LENGTH OF STAY IN 1b 6 yrs. 6 mos.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Children's Center Hospital		d. STREET ADDRESS Family and Child Services	
3 NAME OF DECEASED (Type or print) First Middle Last Dana Cusic		4 DATE OF DEATH Month Day Year November 25, 1967	
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-11-59
9 AGE (In years last birthday) yrs 8		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Institutionalized	
10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Unknown	
14. MOTHER'S MAIDEN NAME Anita Marie Patterson		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) N/A	
16. SOCIAL SECURITY NO. N/A		17. INFORMANT Address Children's Center Hospital, Laurel, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Spastic quadriplegia - cerebral agenesis DUE TO (c) Convulsive disorder			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 18, 1961 , to November 25, 1967 , that (I) (we) last saw the deceased alive on November 25, 1967 , and that death occurred at 2:50 PM , from causes and on the date stated above.			
22a. SIGNATURE James E. Boyland		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) JAMES E. BOYLAND, M. D.		22d. ADDRESS Children's Center Hospital, Laurel, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11-29-67	23c. NAME OF CEMETERY OR CREMATORY Children's Center	23d. LOCATION (City or Town) (County) (State) Laurel A. A. Md.
24. FUNERAL DIRECTOR De Witt Donaldson		25a. REC'D BY REGISTRAR DATE NOV 27 1967	
25b. REGISTRAR'S SIGNATURE W. H. Hammond			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 months after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Page 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14800

14808

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Res. denote before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 4 hrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - Edgewater	
		d. STREET ADDRESS Rt-3, Box-759	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last DAVIS		4. DATE OF DEATH Month Day Year November 6 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 6, 1967
9. AGE (in years last birthday) yrs 6		10. F UNDER 1 YEAR Months Days Hours Min 6 5	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newborn		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Anne Arundel, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME WILLARD R. DAVIS		14. MOTHER'S MAIDEN NAME CAROL A. SAER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT WILLARD R. DAVIS #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 7730 IMMEDIATE CAUSE (a) Respiratory failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hyaline membrane disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 hrs.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) this hospital attended the deceased from Nov. 6, 1967 , to Nov. 6, 1967 , that (i) we saw the deceased alive on Nov. 6, 1967 , and that death occurred at 3:35 PM M, from causes and on the date stated above		22a. SIGNATURE Antonio M. Rivera M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Antonio M. Rivera, M.D.		22d. ADDRESS South River Med. Cent., Edgewater, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11-8-67	
23c. NAME OF CEMETERY OR CREMATORY HILLCREST		23d. LOCATION (City or town) (County) (State) ANNAPOLIS MD.	
24. FUNERAL DIRECTOR John H. Taylor		25a. REC'D BY REGISTRAR NOV 9 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17883

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN TB Deale	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS Rt. 1, Box 184	
3. NAME OF DECEASED (Type or print) First Middle Last Margaret Sheehy DE MUTH		4. DATE OF DEATH Month Day Year November 29 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 16, 1907
9. AGE (In years last birthday) 60 yrs		10. IF UNDER 1 YEAR Months Days 60	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		12. KIND OF BUSINESS OR INDUSTRY	
13. BIRTHPLACE (County & State, or foreign country) Washington, D. C.		14. CITIZEN OF WHAT COUNTRY? U. S.	
15. FATHER'S NAME Joseph & Sheehy		16. MOTHER'S MAIDEN NAME EMMA V. Schu	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		18. SOCIAL SECURITY NO	
19. INFORMANT John R DeMuth, Deale, Md.		Address	
1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of uterus with 11/7/67 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) abdominal metastases DUE TO (c) 18 mo		INTERVAL BETWEEN ONSET AND DEATH 18 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 11/7/66 , 19 19 , to 11/29/67 , 19 19 , that (I) (we) lost saw the deceased alive on 11/29/67 , 19 19 , and that death occurred at 9:15 P.M. from causes and on the date stated above.			
22a. SIGNATURE Charles H. Wirth, M.D.		22b. DATE SIGNED 11/29/67	
22c. PHYSICIAN'S NAME (Type) Charles H. Wirth, M.D.		22d. ADDRESS Lothian, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12-2-67	23c. NAME OF CEMETERY OR CREMATORY Our Lady of Sorrows	23d. LOCATION (City or town) (County) (State) Owensville, AA Md
24. FUNERAL DIRECTOR Bernard Hardisty		25a. REC'D BY REGISTRAR DEC 12 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14801

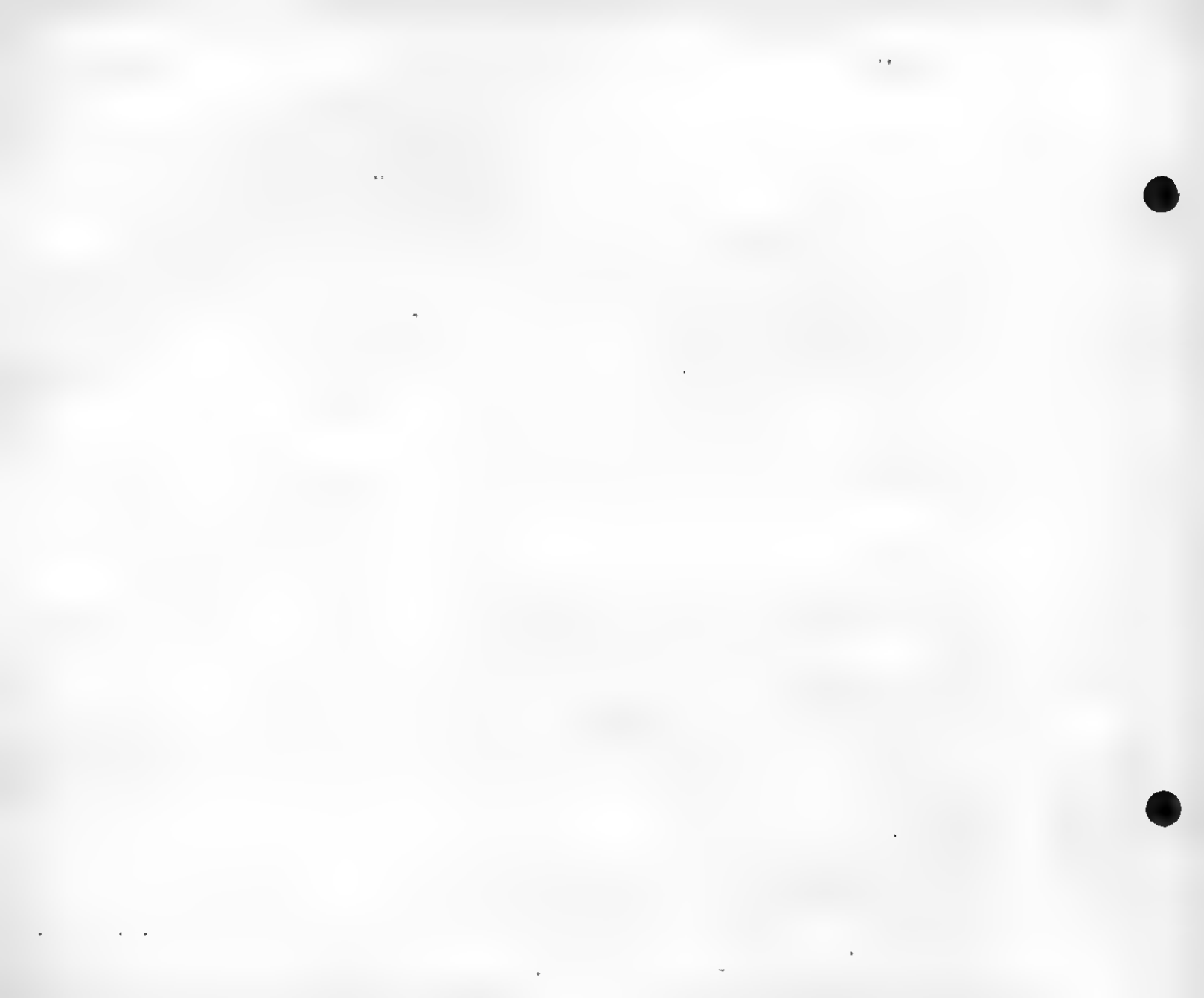
14869

1. PLACE OF DEATH a. COUNTY <div style="text-align: center;">ANNE ARUNDEL MARYLAND</div>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <div style="text-align: center;">MARYLAND</div> b. COUNTY <div style="text-align: center;">ANNE ARUNDEL</div>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <div style="text-align: center;">RURAL-GLEN BURNIE</div>		c. LENGTH OF STAY IN 1b <div style="text-align: center;">4 DAYS</div>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <div style="text-align: center;">NORTH ARUNDEL GENERAL HOSPITAL</div>		e. STREET ADDRESS <div style="text-align: center;">BOX 12 CECIL AVE.</div>	
3. NAME OF DECEASED (Type or print) <div style="text-align: center;">GUSTAV ADOLPH DILL</div>		4. DATE OF DEATH <div style="text-align: center;">NOVEMBER 20 1967</div>	
5. SEX <div style="text-align: center;">MALE</div>	6. COLOR OR RACE <div style="text-align: center;">WHITE</div>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <div style="text-align: center;">OCTOBER 3, 1895</div>
9. AGE (In years last birthday) <div style="text-align: center;">72 yrs</div>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <div style="text-align: center;">POLICEMAN</div>		10b. KIND OF BUSINESS OR INDUSTRY <div style="text-align: center;">LAW ENFORCEMENT</div>	
11. BIRTHPLACE (County & State, or foreign country) <div style="text-align: center;">BALTIMORE, MARYLAND</div>		12. CITIZEN OF WHAT COUNTRY? <div style="text-align: center;">USA</div>	
13. FATHER'S NAME <div style="text-align: center;">Charles William Dill</div>		14. MOTHER'S MAIDEN NAME <div style="text-align: center;">Elizabeth Hefner</div>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <div style="text-align: center;">yes WW I</div>		16. SOCIAL SECURITY NO. <div style="text-align: center;">215-32-1430</div>	
17. INFORMANT <div style="text-align: center;">MRS ANNA DILL</div>		Address <div style="text-align: center;">BOX 12 CECIL AVE MILLERSVILLE</div>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Septicemia (cholecytis)</u> DUE TO <u>Cholelithiasis</u> DUE TO <u>Renal failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <div style="text-align: center;">19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></div>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <div style="text-align: center;">19</div>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11/16</u> , 19 <u>67</u> to <u>11/19</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11/19</u> , 19 <u>67</u> , and that death occurred at <u>12:00</u> AM, from causes and on the date stated above.			
22a. SIGNATURE <div style="text-align: center;">Arsevio Santos MD</div>		22b. DATE SIGNED <div style="text-align: center;">11.20.67</div>	
22c. PHYSICIAN'S NAME (Type) <div style="text-align: center;">ARSEVIO SANTOS MD</div>		22d. ADDRESS <div style="text-align: center;">3350 Wilkens Dr</div>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <div style="text-align: center;">Burial</div>		23b. DATE THEREOF <div style="text-align: center;">11/24/67</div>	
23c. NAME OF CEMETERY OR CREMATORY <div style="text-align: center;">Cedar Hill Cemetery</div>		23d. LOCATION (City or Town) (County) (State) <div style="text-align: center;">Brooklyn A.A. Md.</div>	
24. FUNERAL DIRECTOR <div style="text-align: center;">Hopping Funeral Home - Annapolis, Md.</div>		25a. REC'D BY REGISTRAR <div style="text-align: center;">DATE NOV 22 1967</div>	
25b. REGISTRAR'S SIGNATURE <div style="text-align: center;">[Signature]</div>		25c. REGISTRAR'S NAME <div style="text-align: center;">[Name]</div>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS 14
20 M 146



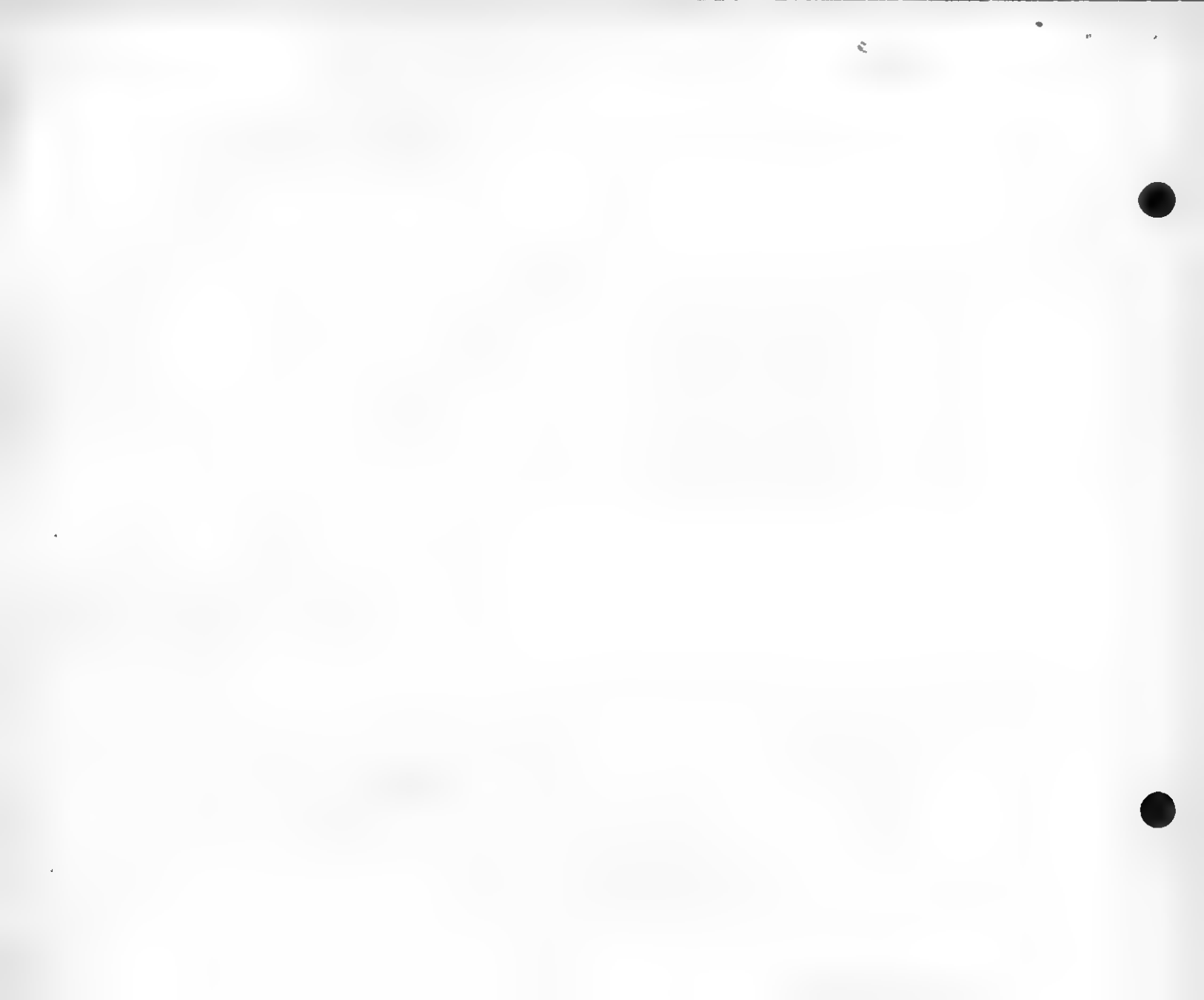
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14810

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PMS-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY H.A. CO. MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution or Residence before admission) a. STATE MD b. COUNTY HACO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b 1111	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. North. Aron del. Hosp.		e. STREET ADDRESS 7215 Judy Rd.	
3 NAME OF DECEASED (Type or print) ANGELO		4 DATE OF DEATH Month 11 Day 27 Year 1967	
5 SEX M	6 CO. OR OR RACE W	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 9-16-28
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Production mgr.		10b KIND OF BUSINESS OR INDUSTRY Bonded Agent of ins.	
11 BIRTHPLACE (State or foreign country) New York		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Vito DiLanardo		14 MOTHER'S MAIDEN NAME (unknown)	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 1950-1952 103-20-7559		16 SOCIAL SECURITY NO 1950-1952 103-20-7559	
17 INFORMANT MRS Gloria M. DiLanardo Same as #2		Address (Wife)	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY 4201 IMMEDIATE CAUSE (a) Coronary Artery Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) (c)		INTERVAL BETWEEN ONSET AND DEATH Death	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a)			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE E. Linhardt		22. DATE SIGNED 11-22-67	
EXAMINER'S NAME (Type) E. Linhardt		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street city, town, or county)	
23a BURIAL CREMATION REMOVAL (Specify) Burial	23b DATE THEREOF Nov. 27, 1967	23c NAME OF CEMETERY OR CREMATORY Baltimore National	23d LOCATION (City or town) (County) (State) Baltimore, Md
24 FUNERAL DIRECTOR E. B. Fleming		25a REC'D BY REG. STR. NOV 27 1967	
25b REGISTRAR'S SIGNATURE Charles Judge		25c REGISTRAR'S SIGNATURE	



14803

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and return them to the State Dept. of Health. This certificate should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY ANNE ARUNDEL MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE MARYLAND b COUNTY ANNE ARUNDEL	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FT GEO G MEADE, MARYLAND		c LENGTH OF STAY IN 1b 14 days	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) KIMBROUGH ARMY HOSPITAL		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) JOHN F. DOCKERY, Sr. First Middle Last		4 DATE OF DEATH Month Day Year NOVEMBER 21 1967	
5 SEX MALE	6 COLOR OR RACE CAU	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 19 MARCH 1882
9 AGE (in years last birthday) 85 yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED SOLDIER	
10b KIND OF BUSINESS OR INDUSTRY US ARMY		11 BIRTHPLACE (County & State, or foreign country) HOTSPRING, N.C.	
12 CITIZEN OF WHAT COUNTRY? USA		13 FATHER'S NAME ELISHA DOCKERY	
14 MOTHER'S MAIDEN NAME NANCY WADDELL		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES 1901-1936	
16 SOCIAL SECURITY NO 218-22-9200		17 INFORMANT Address VIRGINIA DOCKERY (W) SAME AS # 2d/c	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 465X MASSIVE BILATERAL PULMONARY EMBOLISM DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO DUE TO DUE TO			INTERVAL BETWEEN ONSET AND DEATH 30 Min
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f (City or town) (County) (State)
21 I certify that (I) (the hospital) attended the deceased from 7 Nov 1967, to 21 Nov 67, 1967, that (I) (we) last saw the deceased alive on 21 Nov 67 1967, and that death occurred at 7:55 AM, from causes and on the date stated above.			
22a SIGNATURE Louis A. Frederick		22b DATE SIGNED 21 NOV 67	
22c PHYSICIAN'S NAME (Type) LOUIS A. FREDERICK, CPT, MC		22d ADDRESS KIMBROUGH AH FT GEO G MEADE, MD	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF Nov. 25, 1967	23c NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Pk	23d LOCATION (City or Town) (County) (State) Glen Burnie, Maryland
24 FUNERAL DIRECTOR CB Fleming		25a REC'D BY REGISTRAR DATE NOV 22 1967	25b REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14804

14812

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before adm ssion) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 021	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 75 W. Washington St.	
3 NAME OF DECEASED (Type or print) Clara Maude First Middle Last		4 DATE OF DEATH Month Day Year November 10 19 67	
5 SEX Female	6. COLOR OR RACE Negro	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 18, 1919
9. AGE (in years lost birthday) 48 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY *****	
11 BIRTHPLACE (County & State, or foreign country) Annapolis Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Issac Jones		14. MOTHER'S MAIDEN NAME Georgia Green	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No *****		16. SOCIAL SECURITY NO None	
17. INFORMANT Peggy Donegan		Address 75 W. Washington St	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hemorrhagic Shock of liver DUE TO Failure - Spontaneous Rupture of Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Liver Capsule - Carcinoma liver DUE TO (c) 24 hrs		INTERVAL BETWEEN ONSET AND DEATH 24 hrs	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Tumor of lung. Hypertension			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the doctor) attended the deceased from 11/31, 1967 to Nov. 10, 19 67 that (I) (see) last saw the deceased alive on Nov. 10, 19 67 , and that death occurred at M , from causes and on the date stated above.			
22a. SIGNATURE J. Fred Hawkins, Jr. M.D.		22b. DATE SIGNED 11-10-67	
22c. PHYSICIAN'S NAME (Type) J. Fred Hawkins, Jr. M.D.		22d. ADDRESS 16 Murray Ave., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-13-67	
23c. NAME OF CEMETERY OR CREMATORY Brewer Hill		23d. LOCATION (City or Town) (County) (State) Annapolis A.A.Co Md	
24. FUNERAL DIRECTOR C.E. Hicks, 111 Annapolis, Md		25a. REC'D BY REGISTRAR NOV 14 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with item 203. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14805

14813

1. PLACE OF DEATH a. COUNTY <u>A. D.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>A. D.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hamoville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Dr. C. General</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Benjamin Bowers</u>		4. DATE OF DEATH <u>11-11-67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-30-1910</u>
9. AGE (In years, months, days) <u>57 yrs</u>		10. IF UNDER 1 YEAR: Months <u>11</u> Days <u>11</u> Hours <u>19</u> Min <u>17</u>	
11. USUAL OCCUPATION (Give kind of work done during last of working life. Even if retired) <u>Maintenance</u>		12. CITIZENSHIP OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Milton Bowers</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Brandford</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>1-2-3-4-5-6-7-8-9-0</u>	
17. INFORMANT <u>Gertrude E. Bowers</u>		Address <u>Hamoville, MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anterovascular thrombosis</u> DUE TO (b) <u>Ischemic</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Coronary artery disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year <u>11-11-67</u> Hour a.m. <u>11</u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Hamoville, MD</u>
21. I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>[Signature]</u>		22. DATE SIGNED <u>11-11-67</u>	
EXAMINER'S NAME (Type) <u>E. L. Linhardt</u>		Address (Street, city, town or county) <u>Hamoville, MD</u>	
23a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11-15-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. John's</u>	23d. LOCATION (City or town, County, State) <u>Hamoville, MD</u>
24. FUNERAL DIRECTOR <u>William Rose</u>		25a. REC'D By REG. STR. <u>NOV 13 1967</u>	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14806

CERTIFICATE OF DEATH

14814

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> c. LENGTH OF STAY IN 1b <u>4 Mos.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>North Arundel Convalescent Home</u>				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> d. STREET ADDRESS <u>204 Carroll Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>WALTER DOUGLAS DORSEY</u>		4. DATE OF DEATH <u>11 18 1967</u>		5. SEX <u>Male</u>			
6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/25/1902</u>			
9. AGE (In years last birthday) <u>65</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Assemblyman</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Dorsey, Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Walter Dorsey</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>218-09-7756</u>		17. INFORMANT <u>Vera H. Dorsey</u> <u>204 Carroll Road</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary thrombosis</u> DUE TO <u>generalized arteriosclerosis.</u> (b) _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic cerebral thrombosis</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____							
20c. TIME OF INJURY Hour _____ e.m. _____ p.m. _____ Month _____ Day _____ Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____			
20f. (City or town) _____		20g. (County) _____		20h. (State) _____			
21. I certify that (I) (this hospital) attended the deceased from <u>July 1967</u> to <u>Nov. 18, 1967</u> , that (I) (we) last saw the deceased alive on <u>Nov. 18, 1967</u> , and that death occurred at <u>11:18 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>B. A. de Guzman</u> M.D.				22b. DATE SIGNED <u>11/18/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>B. A. de Guzman M. D.</u>				22d. ADDRESS <u>325 Hospital Drive Glen Burnie Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/20/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemetery</u>			
23d. LOCATION (City, town or county) <u>Glen Burnie, Md.</u>		23e. (State) _____					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond C. Fink</u>				25a. REC'D BY REGISTRAR <u>NOV 20 1967</u>			
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				DATE _____			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

14807

14815

1 PLACE OF DEATH a COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c LENGTH OF STAY IN 1b Annapolis	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d STREET ADDRESS 63 Solomons Island Rd.	
3 NAME OF DECEASED (Type or print) Clarence DOUGLAS		4 DATE OF DEATH Month November Day 29 Year 1967	
5 SEX Male	6 COLOR OR RACE Negro	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH June 25, 1909
9. AGE (in years) 58 yrs		10. UNDER 1 YEAR Months 1 Days 29 Hours 10 Min 10	
10a US. OCCUPATION (Give kind of work done during most of working life, even if retired) Spinner		10b KIND OF BUSINESS OR INDUSTRY Textile	
11 BIRTHPLACE (County & State, or foreign country) North Carolina		12 CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO 244-071054	
17 INFORMANT Estelle Bouie Anna Mc		Address Mc	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Sub arachnoid hemorrhage DUE TO (b) Hypertensive Cardiovascular disease DUE TO (c) 1 day			INTERVAL BETWEEN ONSET AND DEATH 1 day
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)			
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Nov 27, 1967 , to Nov 29, 1967 , that (i) (we) last saw the deceased alive on Nov 29, 1967 , and that death occurred at 10:10 P.M. from causes and on the date stated above.			
22a SIGNATURE R M Smith		22b DATE SIGNED Nov 30, 1967	
22c PHYSICIAN'S NAME (Type) RAY M SMITH M.D.		22d ADDRESS Swann Park Md.	
23a BURIAL CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 12-4-1967	23c NAME OF CEMETERY OR CREMATORY Prince Laron Cemetery	23d LOCATION (City or town) (County) (State) Chesapeake Md.
24 FUNERAL DIRECTOR Walter Reese		25a REC'D BY REGISTRAR DEC 4 1967	
25b REGISTRAR'S SIGNATURE Walter Reese			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

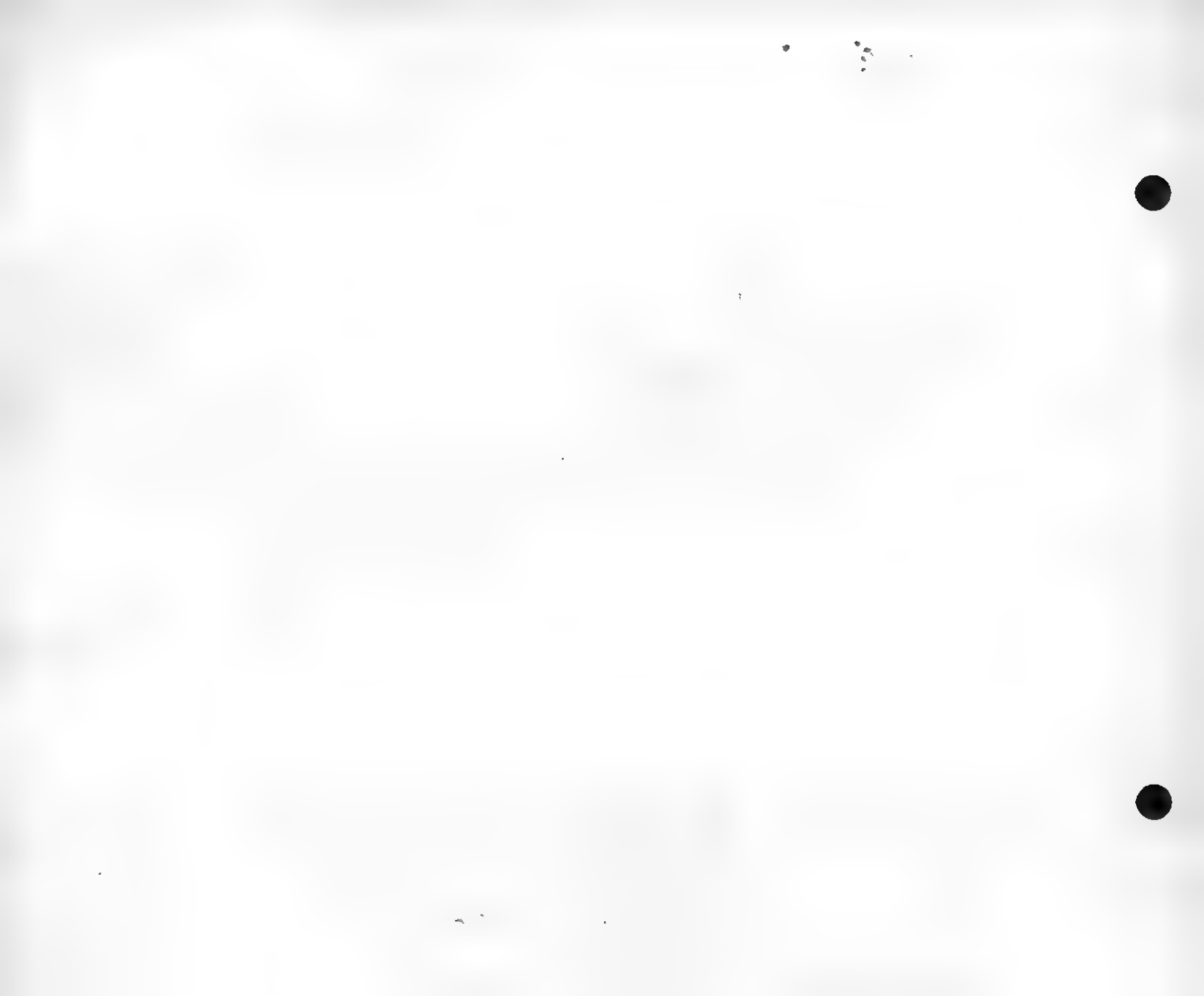
14816

14802

1 PLACE OF DEATH a. COUNTY <u>A.A.CO.</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if first burial on Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>A.A.CO.</u>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>POSDENNA</u>		c. LENGTH OF STAY IN 'b' <u>11-11-67</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>DON-NORTH ARUNDEL - Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>VERNON ECKERT</u>		4 DATE OF DEATH Month <u>11</u> Day <u>28</u> Year <u>1967</u>	
5 SEX <u>MALE</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>1-6-07</u>
9 AGE (In years last birthday) <u>60 yrs</u>		F UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FOREMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GAS & ELEC. Co</u>	
11 BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Julius Eckert</u>		14 MOTHER'S MAIDEN NAME <u>Emma Rudig</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16 SOCIAL SECURITY NO <u>212-05-7055</u>	
17 INFORMANT <u>MARIE ECKERT</u>		Address <u>Portell, Box 1194, Pasadena MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hypertensive C.V.D.</u> 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u> </u> (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u> </u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhardt</u>		22. DATE SIGNED <u>11/28/67</u>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		Address (Street, city, town, or county) <u> </u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12-1-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LONDON PARK</u>	23d. LOCATION (City or town) (County) (State) <u>BALTIMORE, MD</u>
24. FUNERAL DIRECTOR <u>Geo. L. Schwab Funeral Home</u>		25a. RECD BY REGISTRAR <u>Nov 30 1967</u>	
Address <u>Francis & Miller 2101 Frederick Ave</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form DM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <i>Maryland</i> COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Arnold</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Anne Arundel General Hospital</i>		d. STREET ADDRESS <i>Rt. #3 Box 368</i>	
3. NAME OF DECEASED (Type or print) First <i>Mary</i> Middle <i>E</i> Last <i>Edgar</i>		4. DATE OF DEATH Month <i>11</i> Day <i>12</i> Year <i>1967</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4-25-96</i>
9. AGE (In years last birthday) yrs <i>71</i>		10. IF UNDER 1 YEAR Months <i>8</i> Days <i>12</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <i>Balto., Md.</i>		12. CITIZENSHIP OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Frank Foreman</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Wallace</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO <i>None</i>	
17. INFORMANT <i>Calvin H. Edgar, Rt. #3 Box 368 Arnold, Md.</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Drunk Driving</i> DUE TO (b) <i>Alcohol Intoxication</i> stating the underlying cause last (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			
19. INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Fractured Femur, wound infection, Uremia</i>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>Nov 11, 1967</i> to <i>Nov 12, 1967</i> , that (I) (we) last saw the deceased alive on <i>Nov 11, 1967</i> , and that death occurred at <i>12:00 PM</i> from causes and on the date stated above			
22a. SIGNATURE <i>Edward S Beck MD</i>		22b. DATE SIGNED <i>11/2/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>Edward S Beck MD</i>		22d. ADDRESS <i>73 Franklin St Annapolis Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>11-15-67</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Parkwood</i>	23d. LOCATION (City or Town) (County) (State) <i>Balto., Md.</i>
24. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc., 5305 Harford Rd.</i>		25a. REC'D BY REGISTRAR <i>NOV 13 1967</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles J. Jones</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, (Pages 1 and 2) should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GLEN BURNIE</u> c. LENGTH OF STAY IN TB <u>4 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>NORTH ARUNDEL CONV. CENTER</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u> c. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>SEVERN, MARYLAND</u> d. STREET ADDRESS <u>Box #135, Telegraph Rd</u> e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>FLORENCE</u> Middle <u>IOLA</u> Last <u>FISHER</u>						4. DATE OF DEATH Month <u>November</u> Day <u>3</u> Year <u>1967</u>					
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>CAUCAS</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 19, 1912</u>		9. AGE (In years last birthday) <u>55</u> yrs		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>15</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home maker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>ODENTON, MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Mahlon J Hood</u>						14. MOTHER'S MAIDEN NAME <u>Nora May Lowman</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO <u>215-30-0355</u>		17. INFORMANT <u>MR Harold J. Fisher</u> Address <u>(Husband)</u> <u>- same as #2</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of Uter</u> DUE TO <u>left ventricular failure</u> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost <u>Diabetes Mellitus</u> DUE TO <u>Diabetes Mellitus</u> (c) <u>Diabetes Mellitus</u>										INTERVAL BETWEEN ONSET AND DEATH <u>Weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>-</u>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) <u>-</u>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>-</u> p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>-</u>		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>10/31, 1967</u> to <u>11/3, 1967</u> , that (I) (we) last saw the deceased alive on <u>11/3, 1967</u> , and that death occurred at <u>2 PM</u> from causes and on the date stated above											
22a. SIGNATURE <u>Max C Frank</u> M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>						22b. DATE SIGNED <u>11/4/67</u>					
22c. PHYSICIAN'S NAME (Type) <u>MAX C FRANK</u>						22d. ADDRESS <u>425 SE 16th Ave, St Louis, Mo</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Nov 7, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Nichols Bethel Cem.</u>				23d. LOCATION (City or town) (County) (State) <u>Odenton, Md</u>	
24. FUNERAL DIRECTOR <u>Edgar Fleming</u> ADDRESS <u>Singleton Funeral Home Glen Burnie</u>						25a. REC'D BY REGISTRAR <u>NOV 6 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14811

CERTIFICATE OF DEATH

14819

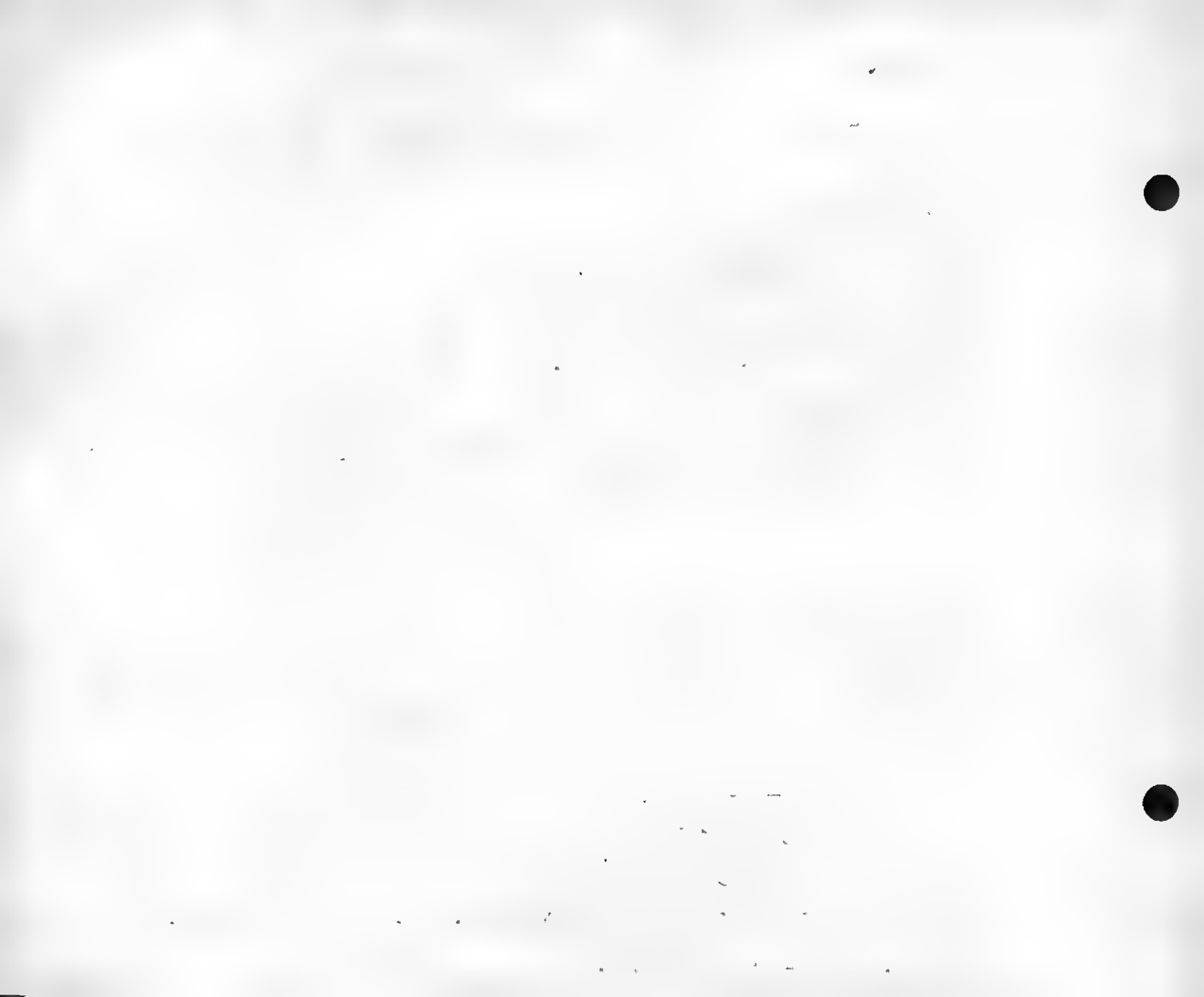
1 PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY IN 1b <u>2 day</u>		d. STREET ADDRESS <u>1217 N. Montford Av.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>EMRIEL</u> First <u>A.</u> Middle <u>Ford</u> Last		4 DATE OF DEATH Month <u>11</u> Day <u>18</u> Year <u>67</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>2-4-83</u> 9 AGE (in years last birthday) <u>84</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ret-Janitor Dept of Education</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State or foreign country) <u>Fairmount, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Oliver FORD</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16 SOCIAL SECURITY NO <u>213-16-3549</u>	
17. INFORMANT <u>John Ford, son, 4013 Biddison Lane</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Chronic Brain Syndrome</u> DUE TO (b) <u>arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>dehydration</u> ; (b) <u>ingestive trauma</u> ; (c) <u>lipoma Rt. lobe</u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour <u>am</u> <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11-15</u> , 19 <u>67</u> to <u>11-18</u> , 19 <u>67</u> ; that (I) (we) last saw the deceased alive on <u>11-18</u> , 19 <u>67</u> , and that death occurred at <u>10:00</u> M, from causes and on the date stated above.			
22a SIGNATURE <u>Errol A. Phillips</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b DATE SIGNED <u>11-18-67</u>	
22c PHYSICIAN'S NAME (Type) <u>ERROL A. PHILLIPS MD</u>		22d ADDRESS <u>Crownsville State Hosp</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>11/22/67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Gardens of Faith</u>	23d LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>Schimunek Funeral Home, Inc.</u> ADDRESS <u>3331 Brehms Lane</u>		25a REC'D BY REGISTRAR DATE <u>NOV 21 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

FOR STATE
HEALTH DEPT.

14820

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessup		c. LENGTH OF STAY IN TB 12-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) House of Correction		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EDWARD Middle F. Last FORREST		4. DATE OF DEATH Month November Day 17 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/10/1915
9. AGE (In years last birthday) 52 yrs		10. IF UNDER 1 YEAR Months 52 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CORRECTIONAL OFFICER		10b. KIND OF BUSINESS OR INDUSTRY STATE OF MD.	
11. BIRTHPLACE (State or foreign country) NEW YORK		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME CHARLES FORREST		14. MOTHER'S MAIDEN NAME LOUISE BASTIAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) YES 10/28/35 2/28/57		16. SOCIAL SECURITY NO 611 468 17	
17. INFORMANT MRS MARTHA P. FORREST - RIDGE, MARYLAND		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY 4221 IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause most (c) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a, b, or c) 4221		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz, M.D.		22. DATE SIGNED 11/18/67	
EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11/21/67	
23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATL. CEM.		23d. LOCATION (City or town) (County) (State) ARLINGTON, VA.	
24. FUNERAL DIRECTOR JOHN M. WELCH - LEONARDTOWN, MD.		25a. REC'D BY REGISTRAR NOV 22 1967	
25b. REGISTRAR'S SIGNATURE John M. Welch		25c. REGISTRAR'S SIGNATURE John M. Welch	



14813

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>A. Arundel County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A. Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville</u>		c. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Millersville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>Box 261 Woodland Rd Millersville, Md</u>	
3. NAME OF DECEASED (Type or print) <u>AMANDA ELONA FORS</u>		4. DATE OF DEATH Month <u>November</u> Day <u>23</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/27/1886</u>
9. AGE (In years last birthday) yrs. <u>81</u>		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>FINLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JUSSI JOHN SALONEN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>257-12-1481</u>	
17. INFORMANT <u>Daughter, Naval Air Station Jacksonville, Florida</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Pneumonia</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10/22/1967</u> to <u>11/23/1967</u> that (I) (we) last saw the deceased alive on <u>11/19/1967</u> and that death occurred at <u>4:20 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Edmond E. Moushabeck</u>		22b. DATE SIGNED <u>11/23/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>EDMOND E. MOUSHABECK</u>		22d. ADDRESS <u>510 MARLEY STATION ROAD GLEN BURNIE, MD. 21061</u>	
23a. BURIAL, CREMATION, REINTERMENT (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11/27/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore Maryland</u>	
24. FUNERAL DIRECTOR <u>HENRY SANDER & SONS INC. BALTO. MD.</u>		25a. REC'D BY REGISTRAR <u>NDV 28 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Henry Sander</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14814

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14022

1. PLACE OF DEATH a. COUNTY AA Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY AA Co			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY in 1b		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Brooklyn - 21225			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) D.O.A. - NORTH ARUNDEL - Hosp.				d. STREET ADDRESS 208 FRANKLIN - AVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Betty Fortson				4. DATE OF DEATH Month Nov Day 17 Year 1967			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 3, 1908		9. AGE (In years last birthday) 59 yrs	10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Walter L Hall				14. MOTHER'S MAIDEN NAME Frederica Myers			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 214-46-0595		17. INFORMANT Family		Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis, generalized DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)					
20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE [Signature] MD				22. DATE SIGNED 11-17-67			
EXAMINER'S NAME (Type) F. Linhardt				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/21/67		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Cem		23d. LOCATION (City or Town) (County) (State) Glen Burnie AA Co Md	
24. FUNERAL DIRECTOR Mc Cully FH 237 Latapex ave				25a. REC'D BY REGISTRAR DATE NOV 20 1967		25b. REGISTRAR'S SIGNATURE [Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15M 7-62

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14815

14823

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>100 President St.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> d. STREET ADDRESS <u>100 President St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
3. NAME OF DECEASED (Type or print) <u>Margarita</u> First <u>Gaston</u> Middle <u>Gaston</u> Last		4. DATE OF DEATH Month <u>11</u> Day <u>16</u> Year <u>1967</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 16, 1897</u>		9. AGE (In years last birthday) <u>70</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (County & State or foreign country) <u>Cardenas (Cuba)</u>		12. CITIZEN OF WHAT COUNTRY? <u>Cuba</u>					
13. FATHER'S NAME <u>Melchor Gaston</u>				14. MOTHER'S MAIDEN NAME <u>Agueda Rosell</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NO</u>				17. INFORMANT <u>Jose I. Lasaga</u> Address <u>#2</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO (b) <u>Coronary sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Generalized arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Chronic Brain Syndrome associated with Cerebral Arteriosclerosis</u>																19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>				20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>August</u> , 19 <u>67</u> , to <u>November</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>November 16</u> , 19 <u>67</u> , and that death occurred at <u>3 PM</u> , from the causes and on the date stated above.																							
22a. SIGNATURE <u>Antonio Fernandez</u> M.D.																22b. DATE SIGNED <u>11-16-67</u>							
22c. PHYSICIAN'S NAME (Type) <u>ANTONIO J. FERNANDEZ</u>																22d. ADDRESS <u>1705 EAST WEST HWY. SILVER SPRING, MD.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>11-18-67</u>				23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>				23d. LOCATION (City, town or county) <u>Annapolis</u>											
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor & Sons Annapolis, Md.</u>																25a. REC'D BY REGISTRAR <u>NOV 20 1967</u>		25b. REGISTRAR'S SIGNATURE <u>John M. Taylor</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form 1003. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and return any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14816

14524

1 PLACE OF DEATH a COUNTY <u>M.A. CO</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>MD</u> b COUNTY			
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Edgewater - Md</u>		c LENGTH OF STAY IN MD		c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Edgewater - Md</u>		d STREET ADDRESS <u>R006 - Bldg 42</u>	
b NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DOA - Anne Arundel General</u>				d IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <u>Ernest</u> Middle <u>W.</u> Last <u>George</u>				4 DATE OF DEATH Month <u>11</u> Day <u>2</u> Year <u>1967</u>			
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>6-18-97</u>		9 AGE (In years last birthday) <u>70</u> yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min <u> </u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. gravedigger</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Cemetery</u>		11 BIRTHPLACE (State or foreign country) <u>Virginia</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Herman George</u>				14 MOTHER'S MAIDEN NAME <u>Elizabeth</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>?</u>		16 SOCIAL SECURITY NO. <u>57-2-07-6879</u>		17 INFORMANT <u>Mrs Cora Page - Edgewater, Md.</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>intercerebral hemorrhage</u> DUE TO <u>4500</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u> </u> DUE TO <u> </u> (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u> </u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a) <u> </u>							
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u> </u>			
20c TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>E. L. Ivins</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>E. L. Ivins</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22. DATE SIGNED <u>11-2-67</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
Address (Street, city, town, or county) <u> </u>				23a NAME OF CEMETERY OR CREMATORY <u>Fr. Lincoln Cemetery</u>			
23b DATE THEREOF <u>11/4/67</u>		23c NAME OF CEMETERY OR CREMATORY <u>Fr. Lincoln Cemetery</u>		23d LOCATION (City or town) (County) (State) <u>Washington D.C.</u>		23e LOCAL REGISTRAR <u>Charles Judge</u>	
24 FUNERAL DIRECTOR <u>Hopping Funeral Home - Annapolis, Md.</u>				25a DATE <u>NOV 6 1967</u>			



CERTIFICATE OF DEATH

14817

14-25

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN lb 40 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS Rt-4, Box-346	
3 NAME OF DECEASED (Type or print) First Middle Last Leo Patrick GLANCEY		4 DATE OF DEATH Month Day Year November 20 19 67	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH March 5, 1907
9 AGE (in years last birthday) yrs. 60		FINDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY OS Contractor	
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12 CITIZEN OF WHAT COUNTRY? U.S.	
13 FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO. 203030137	
17 INFORMANT Mrs Irene Glancey above		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary edema and bronchial pneumonia DUE TO (b) Bacterial endocarditis DUE TO (c) Rheumatic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from 7-13 , 19 67 , to Nov. 20 , 19 67 that (I) (we) last saw the deceased alive on Nov. 20 , 19 67 , and that death occurred at 5:55 PM from causes and on the date stated above			
22a SIGNATURE Ray M. Smith, M.D.		22b DATE SIGNED Nov 21 1967	
22c PHYSICIAN'S NAME (Type) Ray M. Smith, M.D.		22d ADDRESS Hahn Prof Bldg., Severna Park, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 11-24-67	
23c NAME OF CEMETERY OR CREMATORY Parkwood Cem		23d LOCATION (City or town) (County) (State) Parkville Baltimore Md	
24 FUNERAL DIRECTOR Robert S. Baranow, Severna Park, Md		25a REC'D BY REGISTRAR DATE NOV 27 1967	
25b REGISTRAR'S SIGNATURE Charles Judge			

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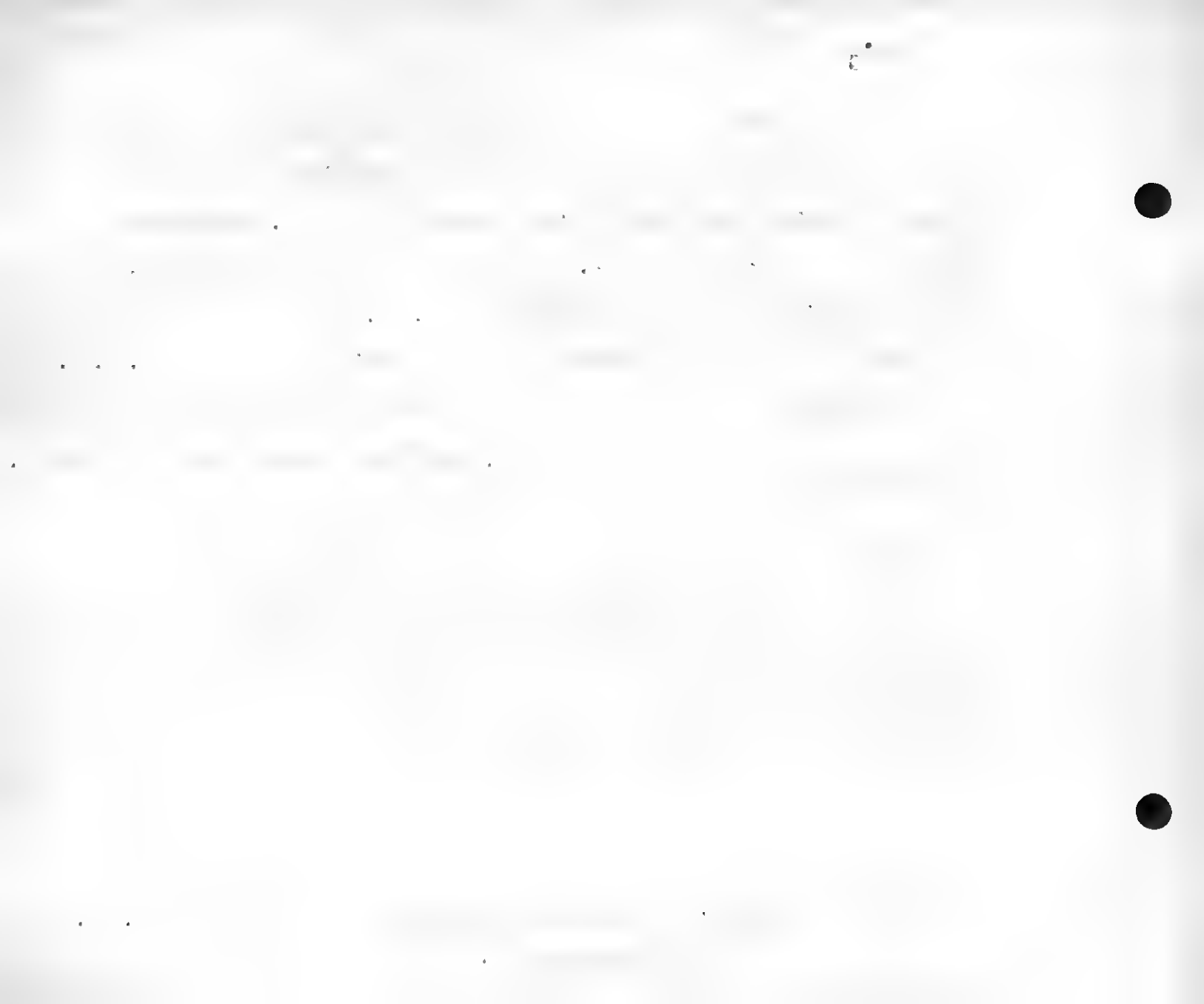
VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b 21061	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 1 Box 290 North Shore Drive		d. STREET ADDRESS Route 1 Box 290 N. Shore Drive	
3. NAME OF DECEASED (Type or print) First George Middle J. Last Glass		4. DATE OF DEATH Month November Day 14 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 23, 1881
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Self Employed	9. AGE (In years last birthday) yrs 86
11. BIRTHPLACE (County & State, or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George Glass		14. MOTHER'S MAIDEN NAME Hannah Margaret Herrman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. Carl Glass		Address Glen Burnie Route 1 Box 290 N Shore Dr.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary heart failure DUE TO (b) ASCVD DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Oct , 19 66 , to Nov 14 , 19 67 , that (I) (we) last saw the deceased alive on Nov 14 , 19 67 , and that death occurred at 4:00 M, from causes and on the date stated above.			
22a. SIGNATURE David Abramson MD		22b. DATE SIGNED 11/15/67	
22c. PHYSICIAN'S NAME (Type) David Abramson MD		22d. ADDRESS 767 Balto Annap Blvd. Glen Burnie	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/18/67	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION (City or town) (County) (State) Anne Arundel Co. Md.
24. FUNERAL DIRECTOR McCully Funeral Home		25a. REC'D BY REGISTRAR Charles Judge	
ADDRESS 237 Patapsco Ave. 21225		DATE NOV 17 1967	

14826



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14819

14827

1 PLACE OF DEATH a. COUNTY ANNE ARUNDEL b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLEN BURNIE c. LENGTH OF STAY IN 1b 3 Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) NORTH ARUNDEL CONVALESCENT CTR.		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 719 S CURLEY ST e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) ANTHONY F. GNACYK		4 DATE DEATH 11 25 19 67	
5. SEX MALE	6. COLOR OR RACE CAUC.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-28-1900
9. AGE (in years last birthday) 67		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired, Foreman	11. BIRTHPLACE (County & State, or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME John Gnacyk	
14. MOTHER'S MAIDEN NAME Angela Daniel		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO 212-09-5082 A		17. INFORMANT (Daughter) Essex, Md. Mrs. Frances Swinder, 226 Back River Neck	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 410X IMMEDIATE CAUSE (a) Intractable congestive heart failure DUE TO RHD with mitral insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cancer of the pancreas, DUE TO suspected (c)		INTERVAL BETWEEN ONSET AND DEATH 12-15 mos. 6-8 weeks	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)		20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f (City or town) (County) (State)		21. I certify that (this hospital) attended the deceased from Nov. 22, 1967 to Nov. 25, 1967 , that (I/we) last saw the deceased alive on Nov. 25, 1967 , and that death occurred at 9:44 AM , from causes and on the date stated above	
22a SIGNATURE D. G. de Kruzman		22b DATE SIGNED 11/25/67	
22c PHYSICIAN'S NAME (Type) B. A. de GUZMAN		22d ADDRESS Suite 108 325 HOSPITAL DR. GLEN BURNIE, MD 21061	
23a BURIAL, CREMATION, REMOVAL, (Specify) Burial		23b DATE THEREOF 11/29/67	
23c NAME OF CEMETERY OR CREMATORY St. Stanislaus Cem.		23d LOCATION (City or Town) (County) (State) Baltimore, Md.	
24 FUNERAL DIRECTOR John J. Duda, 2829 Hudson St. Balto. Md.		25a REC'D BY REGISTRAR DATE NOV 29 1967	
25b REGISTRAR'S SIGNATURE Charles Judge			

1

14820

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14028

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) ✓ a. STATE b. COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		c LENGTH OF STAY IN 1b Washington, D. C.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Children's Center Hospital		d STREET ADDRESS 1429 "U" Street, N. W. e RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Elaine Goldberg		4 DATE OF DEATH Month Day Year November 3 1967	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 10-24-24
9 AGE (In years last birthday) 43 yrs		10 UNDER 1 YEAR Months Days	11 UNDER 24 HRS Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Institutionalized		10b KIND OF BUSINESS OR INDUSTRY -----	11 BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland
12 CITIZEN OF WHAT COUNTRY? USA		13 FATHER'S NAME Jack Goldberg	
14 MOTHER'S MAIDEN NAME Florence Goldberg		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no no ---	
16 SOCIAL SECURITY NO ---		17 INFORMANT Address Children's Center Hospital, Laurel, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO Tuberculosis - active - closed Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Atelectasis (c) Fatty degeneration of the liver		INTERVAL BETWEEN DEATH AND DEATH 1 month	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Convulsive disorder, mental retardation, Microencephaly		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (H) (this hospital) attended the deceased from July 12, 1929 , to Nov. 3, 1967 , that (H) (we) last saw the deceased alive on November 3, 1967 , and that death occurred at 8:30 AM from causes and on the date stated above.			
22a. SIGNATURE Margaret W. Mola		22b. DATE SIGNED Nov. 3, 1967	
22c. PHYSICIAN'S NAME (Type) MARGARET W. MOLA, M. D.		22d. ADDRESS Children's Center, Laurel, Maryland	
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b DATE THEREOF 11/5/67	23c NAME OF CEMETERY OR CREMATORY CHESED-SHELEMMES CEMETERY	23d LOCATION (City or Town) (County) (State) Hillside, Maryland
24 FUNERAL DIRECTOR Bernard Danzansky & Sons		25a. REC'D BY REGISTRAR 3501-14th St., N.W. Washington, D.C. 25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

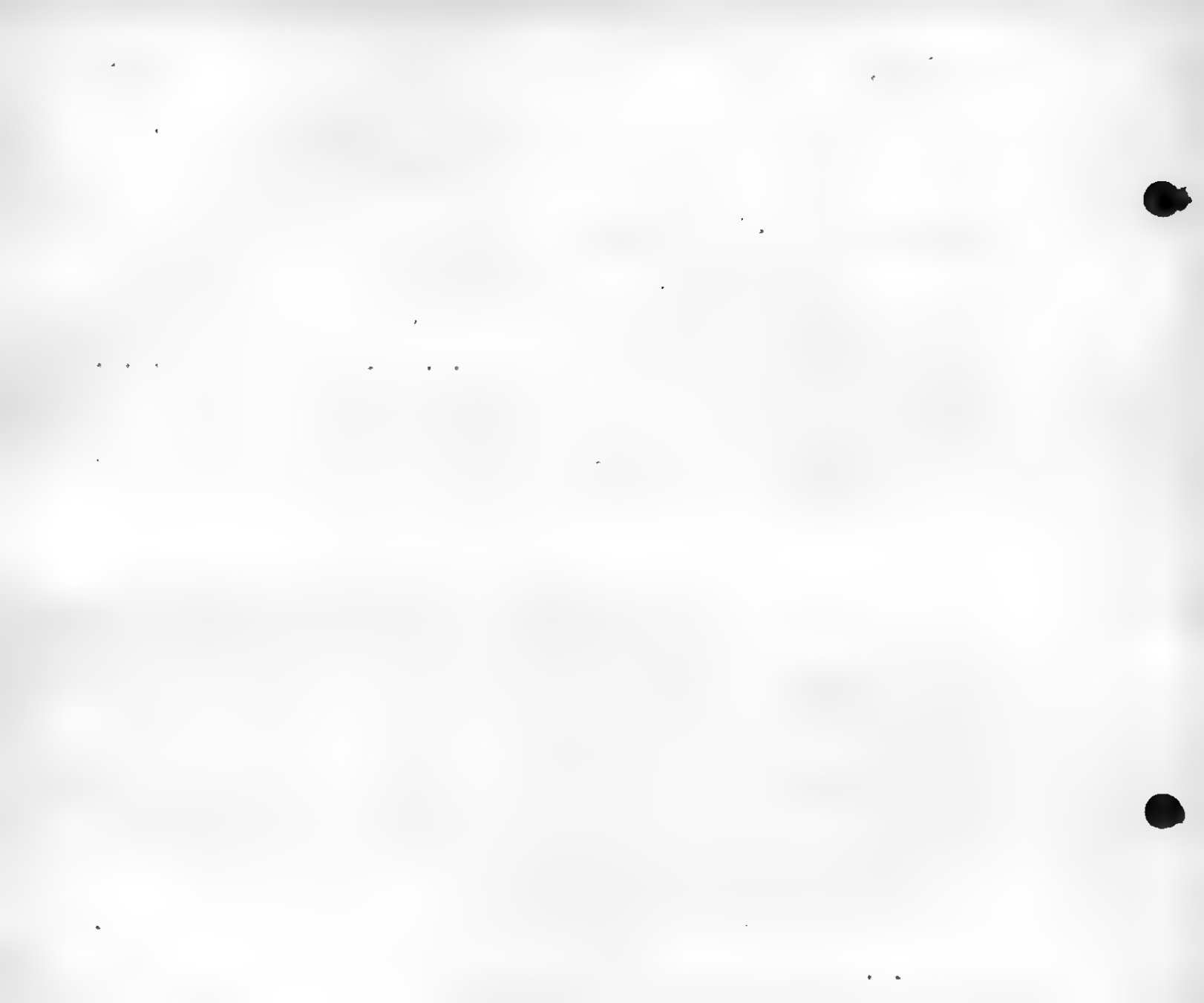
Items 8 & 9 - Film

CERTIFICATE OF DEATH

14821 G-428 - 3/3/70 mcm

14829

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY A.A.Co	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis (Rural)		c. LENGTH OF STAY IN 1b 36	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Annapolis
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rt 3 BayRidge Road Bx 155		d. STREET ADDRESS Rt 3 BayRidge Rd Bx 155	
3. NAME OF DECEASED (Type or print) First Dewford Middle NMN Last Gray		4. DATE OF DEATH Month November Day 6 Year 1967	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/22/17 9. AGE (In years last birthday) 49 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Presser (Cleaners)		10b. KIND OF BUSINESS OR IND. STRY *****	
11. BIRTHPLACE (County & State, or foreign country) A.A. Co. Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ruben Gray		14. MOTHER'S MAIDEN NAME Elmira Parker	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No *****		16. SOCIAL SECURITY NO. 216-12-8104	
17. INFORMANT Augusta Gray Bx 155 Rt 3 Anna.Md		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. 792x IMMEDIATE CAUSE (a) Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH Unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/10 , 19 64 to 11/6 , 19 67 , that (I) (was) last saw the deceased alive on 10/22 , 19 67 , and that death occurred at 9:25 P M, from causes and on the date stated above.			
22a. SIGNATURE Richard I. Hochman M.D.		22b. DATE SIGNED 11/7/67	
22c. PHYSICIAN'S NAME (Type) Richard I. Hochman, Md		22d. ADDRESS 16 Murray Ave, Annapolis, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-10-67	
23c. NAME OF CEMETERY OR CREMATORY Annapolis Neck		23d. LOCATION (City or Town) (County) (State) Annapolis A.A.Co Md	
24. FUNERAL DIRECTOR C.E. Hicks, 111 Annapolis, Maryland		25a. REC'D BY REGISTRAR NOV 14 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14822

14630

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution or Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 317 West St.,	
3. NAME OF DECEASED (Type or print) First Joseph Middle Eliel Last GREENWELL		4. DATE OF DEATH Month November Day 8 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 28, 1893
9. AGE (In years last birthday) 74 yrs		10. IF UNDER 1 YEAR Months 7 Days 4 Hours 15 Min.	11. IF UNDER 24 HRS Hours 15 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) maintenance		10b. KIND OF BUSINESS OR INDUSTRY State roads	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Joseph T.		14. MOTHER'S MAIDEN NAME Roberta Turner	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes I		16. SOCIAL SECURITY NO. 212-14-1749	
17. INFORMANT Clara W. Greenwell - same as #2 above		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ac. large Pul Heart Failure 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic C.V. disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 18 hrs.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a) Old st. Hemiplegia & Possible G.I. Pathology		19. WAS A TOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of form 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from 7/15/1967 to Nov. 7, 1967 that () () lost saw the deceased alive on Nov. 7, 1967 , and that death occurred at 2:00 AM from causes and on the date stated above.			
22a. SIGNATURE Maurice Klawans M.D.		22b. DATE SIGNED 11/9/67	
22c. PHYSICIAN'S NAME (Type) Maurice Klawans, M.D.		22d. ADDRESS 31 Southgate Ave., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/11/67	23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery	23d. LOCATION (City or Town) (County) (State) Annapolis
24. FUNERAL DIRECTOR Bridget E. Hopping		25a. REC'D BY REGISTRAR NOV 14 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. REGISTRAR'S NAME Charles Judge	



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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
14822					14831				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)				
a. COUNTY Anne Arundel MARYLAND					a. STATE Maryland b. COUNTY Anne Arundel				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis,				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital					d. STREET ADDRESS 210A Hilltop Lane, Apt. 203				
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
First Anne Middle Marie Last GRYCKO					Month November Day 23 Year 1967				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 5, 1917		9. AGE (In years last birthday) 50 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MEDICAL TECH.		10b. KIND OF BUSINESS OR INDUSTRY Hospital		11. BIRTHPLACE (County & State, or foreign country) Carbondale, Pennsylvania			12. CITIZEN OF WHAT COUNTRY? U. S.		
13. FATHER'S NAME William L. SANDERS					14. MOTHER'S MAIDEN NAME FLORENCE BERGE				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO		17. INFORMANT BEN J. Grycko #2		
18. CAUSE OF DEATH (Enter only one cause per one for (a), (b), and (c))					INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY.									
IMMEDIATE CAUSE (a) Pneumonia					24 hr				
DUE TO									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					(b) Pleural effusion and marked leukopenia 2 weeks				
					DUE TO				
					(c) Multiple + massive metastases secondary to 1 yr				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
Marked anemia.									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.					20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from June , 19 67 , to Nov 23, 1967 , that (I) (we) last saw the deceased alive on 11/22/67 , and that death occurred at 3:25 A.M. M, from causes and on the date stated above									
22a. SIGNATURE Robert R. Riey Jr. M.D.					ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 11/24/67		
22c. PHYSICIAN'S NAME (Type) ROBERT RIEY JR.					22d. ADDRESS Annapolis, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		11-27-67		HILLCREST		Annapolis A.A. MD.			
24. FUNERAL DIRECTOR John M. Lyndon Annapolis, Md.					25a. REC'D BY REG-STRAR NOV 28 1967		25b. REGISTRAR'S SIGNATURE William J. ...		



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P-43. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18, 19, 21
film #395
12-6-67 mt

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14824 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14-32

1 PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Davidsonville c. LENGTH OF STAY IN 1b 14824		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE Maryland b. COUNTY Davidsonville c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Davidsonville d. STREET ADDRESS Davidsonville, Maryland e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) EMMA		4 DATE OF DEATH Month November Day 4 Year 1967	
5 SEX Female	6 COLOR OR RACE Negro	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 3-7-1927
9 AGE (In years last birthday) 40		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (State or foreign country) MD		12. CITIZENSHIP OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Johnson		14. MOTHER'S MAIDEN NAME Emma Maynard	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO James L. Harris Davidsonville MD	
17. INFORMANT James L. Harris Davidsonville MD		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Alcoholic Intoxication DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Cardiovascular Disease			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o m p m 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MED. CA. EXAMINER <input checked="" type="checkbox"/> DEPUTY MED. CA. EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
22. DATE SIGNED 11/6/67			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1-9-1967	23c. NAME OF CEMETERY OR CREMATORY Pine Lawn	23d. LOCATION (City or Town) (County) (State) Chesapeake MD
24. FUNERAL DIRECTOR William Reese		25a. REC'D BY REGISTRAR NOV 10 1967	
ADDRESS Chesapeake MD		25b. REGISTRAR'S SIGNATURE James L. Harris	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14825

CERTIFICATE OF DEATH

14833

1 PLACE OF DEATH a COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Anne Arundel	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c LENGTH OF STAY IN 1b 0	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		e STREET ADDRESS 38 Franklin Street	
3 NAME OF DECEASED (Type or print) First Middle Last Roberta Fauntleroy HEALY		4 DATE OF DEATH Month Day Year November 22 19 67	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 29, 1889
9 AGE (In years last birthday) 77 yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SCHOOL TEACHER	
10b KIND OF BUSINESS OR INDUSTRY Public Schools		11. BIRTHPLACE (County & State, or foreign country) Virginia	
12 CITIZEN OF WHAT COUNTRY? U. S.		13. FATHER'S NAME Granville S. Healy	
14. MOTHER'S MAIDEN NAME Mary Taliaferro		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Yes CAREY L. MEREDITH #2	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cancer of breast		INTERVAL BETWEEN ONSET AND DEATH 2 hrs	
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 11/20 to 11/22 , 19 67 that (I) (we) last saw the deceased alive on 11/22 , 19 67 , and that death occurred at 6:05 P.M. M, from causes and on the date stated above	
22a. SIGNATURE [Signature]		22b DATE SIGNED 11/28/67	
22c PHYSICIAN'S NAME (Type)		22d ADDRESS	
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE THEREOF 11/25/67	
23c NAME OF CEMETERY OR CREMATORY CEADR Bury		23d LOCAT ON (City or Town) (County) (State) ANNAPOLIS A.A. MD.	
24. FUNERAL DIRECTOR [Signature]		25a REC'D BY REGISTRAR NOV 28 1967	
25b REGISTRAR'S SIGNATURE [Signature]		25c REGISTRAR'S NAME [Signature]	



14826

CERTIFICATE OF DEATH

14834

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Anne Arundel</u>		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. LENGTH OF STAY IN 15 <u>4 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North Arundel Hospital</u>				d. STREET ADDRESS <u>7689 Briar Lane</u>	
3 NAME OF DECEASED (Type or print) <u>Visa M. Hess</u>				4 DATE OF DEATH Month <u>November</u> Day <u>26</u> Year <u>1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-14-91</u>	9 AGE (In years lost birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>	
13. FATHER'S NAME <u>Henry Miller</u>		14. MOTHER'S MAIDEN NAME <u>(Unknown)</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>212 52 3125</u>		17. INFORMANT <u>Mr. Silas Honaker (son) Baltimore, Md.</u>	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <u>443X</u> IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> DUE TO (b) <u>Hypertensive Cardiovascular disease</u> DUE TO (c) <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>weeks</u> <u>year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11/12, 1967</u> to <u>11/26, 1967</u> , that (I) (we) last saw the deceased alive on <u>11/26, 1967</u> , and that death occurred at <u>7:30 P.M.</u> from causes and on the date stated above.					
22a. SIGNATURE <u>Max C Frank MD</u>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>11/27/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>MAX C FRANK MD</u>		22d. ADDRESS <u>425 SE Ritchie Hwy Glen Burnie</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Nov. 29/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Glen Burnie, Maryland</u>	
24. FUNERAL DIRECTOR <u>Singleton</u>		ADDRESS <u>Singleton Funeral Home</u> <u>Glen Burnie, Maryland</u>		25a. REC'D BY REGISTRAR <u>NOV 29 1967</u> DATE	
				25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

14827

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14835

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Marys</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KADIANT L'ALLEE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bay Manor Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mary Romaine Hicks</u>		4. DATE OF DEATH <u>Nov. 13, 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 16, 1890</u>
9. AGE (in years last birthday) <u>77</u> yrs		10. US. AL. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (County & State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Alvin McCall</u>		14. MOTHER'S MAIDEN NAME <u>Koxanne Gibney</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u>—</u>	
17. INFORMANT <u>Grace Reed</u>		18. ADDRESS <u>4417 73rd Ave. Bellemead, Md.</u>	
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetes mellitus with</u> DUE TO <u>dehydration and anoxia and</u> DUE TO <u>pyelonephritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>arteriosclerotic cardiovascular disease</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1967</u> , that (I) (we) last saw the deceased alive on <u>Nov 12</u> , 19 <u>67</u> , and that death occurred at <u>2:20 AM</u> , from causes on and on the date stated above			
22a. SIGNATURE <u>Ray Smith</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Ray Smith</u>		22d. ADDRESS <u>St. Marys, Annapolis, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Nov 15, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln Cemetery</u>	23d. LOCATION (City or town) (County) (State) <u>Colmar Manor Pro Geo Md.</u>
24. FUNERAL DIRECTOR <u>N. Gasch's Sons</u>		25a. REC'D BY REGISTRAR <u>NOV 17 1967</u>	
ADDRESS <u>Hyattsville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

VR A15 (4)
25M 1/67

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 1 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14836

1 PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if instit' on Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNE ARUNDEL</u>		c. LENGTH OF STAY IN b. <u>CRIMINAL</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. - Anna Handel General</u>		d. STREET ADDRESS <u>Summerhill Trailer Park</u>	
3. NAME OF DECEASED (Type or print) <u>Ronda</u> First Middle Last <u>CHOLZ</u>		4. DATE OF DEATH Month <u>11</u> Day <u>3</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-22-67</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Ronald C. Holz</u>		14. MOTHER'S MAIDEN NAME <u>Dianne Henderson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		17. INFORMANT <u>Ronald C Holz - same as #2 above</u>	
16. SOCIAL SECURITY NO <u>---</u>		18. INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>	
1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Respiratory Infection S.D.I.I.</u> DUE TO (b) <u>---</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) <u>---</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhardt</u> M.D.		22. DATE SIGNED <u>11-3-67</u>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASS STANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11/5/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Annapolis MD</u>
24. FUNERAL DIRECTOR <u>Beulah E. Huggins</u> ADDRESS <u>Hopping Funeral Home Annapolis, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 6 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14828

14837

1 PLACE OF DEATH a COUNTY <i>Anne Arundel</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>BALTIMORE</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Burnie</i>		c. LENGTH OF STAY IN 1b <i>BALTIMORE</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>North Annapolis Convalescent Center</i>		d. STREET ADDRESS <i>1215 NEIGHBOR AVE</i>	
3 NAME OF DECEASED (Type or print) <i>CATHERINE M. HOOVER</i>		4 DATE OF DEATH Month <i>11</i> Day <i>22</i> Year <i>1967</i>	
5 SEX <i>FEMALE</i>	6 COLOR OR RACE <i>WHITE</i>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <i>12-17-87</i>
9 AGE (in years) <i>79</i> yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>
11 BIRTHPLACE (County & State, or foreign country) <i>Baltimore Co. Maryland</i>		12 CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13 FATHER'S NAME <i>John Myers</i>		14. MOTHER'S MAIDEN NAME <i>Katie Meeter</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16 SOCIAL SECURITY NO. <i>717-07-7176</i>	
17 INFORMANT <i>Henry Meyers</i>		Address <i>1328 Seiling Avenue</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Left ventricular failure</i> DUE TO (b) <i>Carcinoma of bladder</i> DUE TO (c) <i>Diabetes Mellitus</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Hours</i> <i>Months</i> <i>Years</i>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Left aortic coronary fistula</i>		19 WAS A Topsy PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>11/1</i> , 19 <i>67</i> to <i>11/22</i> , 19 <i>67</i> that (I) (we) last saw the deceased alive on <i>11/22</i> , 19 <i>67</i> , and that death occurred at <i>4:30</i> AM, from causes and on the date stated above.			
22a. SIGNATURE <i>Max C Frank</i>		22b. DATE SIGNED <i>11/22/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>MAX C FRANK MD</i>		22d. ADDRESS <i>425 So Ritchie Hwy Glen Burnie Md</i>	
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>11-25-1967</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Zion Lutheran Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Baltimore Co. Md.</i>
24 FUNERAL DIRECTOR <i>Lassahn Funeral Home 2401 Belair Road</i>		25a REC'D BY REGISTRAR <i>36</i>	
25b REG STRAR'S SIGNATURE <i>[Signature]</i>		DATE <i>NOV 27 1967</i>	

14828

CERTIFICATE OF DEATH

14838

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if instit on Residence before adm ssion) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b Glen Burnie	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital		d. STREET ADDRESS 500 Balto. & Annapolis Blvd.	
3 NAME OF DECEASED (Type or print) Robert G. Houck		4 DATE OF DEATH Month 11 Day 27 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-7-13
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bartender		10b. KIND OF BUSINESS OR INDUSTRY Night Club	
11. BIRTHPLACE (County & State, or foreign country) Patapsco, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Claude Houck		14. MOTHER'S M A D E N NAME Ella Rohrbaugh	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown		16. SOCIAL SECURITY NO. 216 07 4691	
17. INFORMANT Mrs. Theresa M. Houck (wife)		Address Same As #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Myocardial infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) AS HD DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) GI ulceration liver cirrhosis			
19. WAS A. TOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/20/66 19 to 11/27/67 19, that (I) (we) last saw the deceased alive on 11/25/67 19, and that death occurred at 12:05 M, from causes and on the date stated above			
22a. SIGNATURE J. B. RAMIREZ		22b. DATE SIGNED 11/27/67	
22c. PHYSICIAN'S NAME (Type) J. B. RAMIREZ		22d. ADDRESS 3521 ANNAPOLIS RD BALTO 27 MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Nov. 30/67	
23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Park		23d. LOCATION (City or Town) (County) (State) Glen Burnie, Maryland	
24. FUNERAL DIRECTOR Singleton Funeral Home		25a. REC'D BY REGISTRAR NOV 29 1967	
25b. REGISTRAR'S SIGNATURE Charles J. J...			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2, and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal.

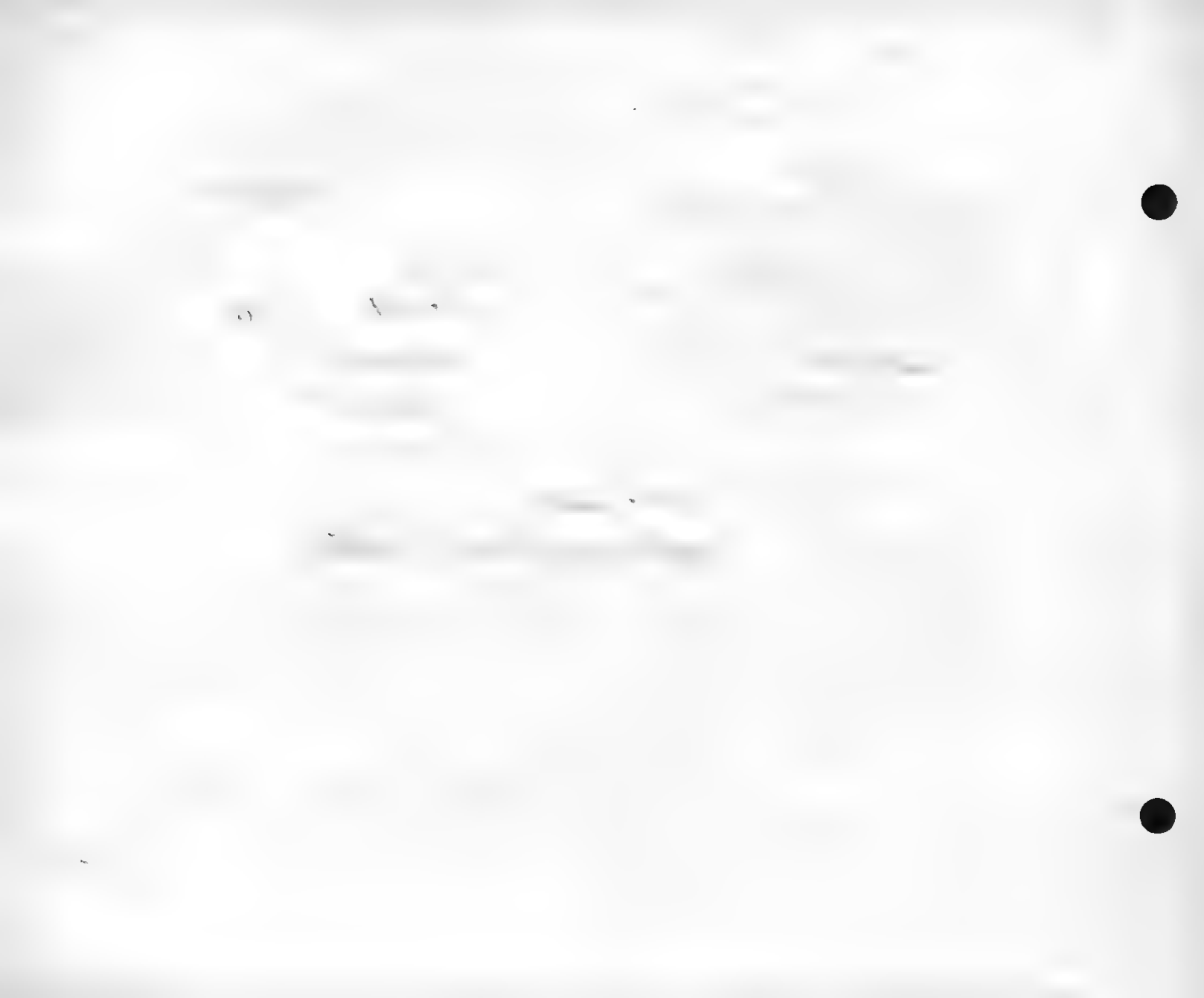
CERTIFICATE OF DEATH

14830

1. PLACE OF DEATH a. COUNTY <u>Crownsville State Hospital</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>---</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY IN <u>24 days</u>		d. STREET ADDRESS <u>900 Argyle Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Carrie</u> Middle <u>Howard</u> Last <u>Howard</u>		4. DATE OF DEATH Month <u>11</u> Day <u>4</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/14/07</u>
9. AGE (In years last birthday) <u>60</u>		10. IF UNDER 1 YEAR Months <u>---</u> Days <u>---</u> Hours <u>---</u> Min <u>---</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>factory</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN Boggs</u>		14. MOTHER'S MAIDEN NAME <u>unknown Sallie Boggs</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>---</u>		16. SOCIAL SECURITY NO <u>212-18-7911</u>	
17. INFORMANT <u>HOSPITAL Record.</u>		Address <u>---</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: 731x IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO (b) <u>paget's disease + HCV D + diabetes</u> DUE TO (c) <u>---</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF OTHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>---</u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from <u>10/13/67</u> , 19 <u>---</u> , to <u>11/4/67</u> , 19 <u>---</u> , that (H) (we) last saw the deceased alive on <u>11/4/67</u> , 19 <u>---</u> , and that death occurred at <u>5 P</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>11/4/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>L. RENEZIL M.D.</u>		22d. ADDRESS <u>Crownsville State Hospital</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11-8-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bosto. Nat'l Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Balto. Md</u>
24. FUNERAL DIRECTOR <u>Morton + S. Light 1701 W. Calver</u>		25a. REC'D BY REGISTRAR <u>NOV 6 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14831

CERTIFICATE OF DEATH

14840

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie c. LENGTH OF STAY IN b 1 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linthicum d. STREET ADDRESS 716 E. Maple Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Margaret Middle Josephine Last Howard		4. DATE OF DEATH Month 11 Day 29 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-19-1891
9. AGE (In years last birthday) 76		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Horner		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 213-54-1885	
17. INFORMANT Mrs. Barbara L. Beard, 716 E. Maple Road		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY 4201 IMMEDIATE CAUSE (a) CORONARY THROMBOSIS DUE TO (b) CORONARY ATHEROSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTESTINAL VIRUS INFECTION + VIRUS BRONCHITIS		INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE 10 YRS.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from JAN. 28, 1966 to MAY 29, 1967 , that (I) (we) last saw the deceased alive on MAY 27, 1967 , and that death occurred at 8:20 P.M. from causes and on the date stated above.			
22a. SIGNATURE Leon C. Perry		22b. DATE SIGNED 12-1-67	
22c. PHYSICIAN'S NAME (Type) Dr. Leon C. Perry		22d. ADDRESS 325 Hospital Drive, Glen Burnie, Md.	
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 12-4-1967	23c. NAME OF CEMETERY OR CREMATORY Poplar Grove Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore County, Maryland
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Avenue 21229		25a. REC'D BY REGISTRAR DATE DEC 6 1967	
		25b. REGISTRAR'S SIGNATURE William J. Suter	



CERTIFICATE OF DEATH

14832

14841

1. PLACE OF DEATH <u>COOPER CONVELENT HOME</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
a. COUNTY <u>Ann Arundel</u>	b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>GLEN BURNIE</u>	a. STATE <u>MD.</u>	b. COUNTY <u>BALTIMORE</u>
c. LENGTH OF STAY IN b. <u>106</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>4001 Woodridge Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>COOPER CONU. HOME</u>		d. STREET ADDRESS <u>4001 Woodridge Road</u>	
3. NAME OF DECEASED (Type or print) <u>MARSHALL E. JACKSON</u>		4. DATE OF DEATH <u>NOV. 1 1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/13/1879</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Sarah Perry Jackson</u>		14. MOTHER'S MAIDEN NAME <u>Sarah</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>220-09-5116</u>	
17. INFORMANT <u>E. GALLERY JR.</u>		Address <u>3 THOMAS ST. GLEN BURNIE, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) <u>Atherosclerotic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Several days</u> <u>Unknown</u> <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>no</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>5/14/66</u> , 19 <u>66</u> , to <u>11/1/67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11/1/67</u> , 19 <u>67</u> , and that death occurred at <u>12:30 PM</u> , from the causes and on the date stated above			
22a. SIGNATURE <u>Richard H. Hunt, M.D.</u>		22b. DATE SIGNED <u>NOV 3 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Richard H. Hunt</u>		22d. ADDRESS <u>Rockville, Glen Burnie, Md 21061</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11/4/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hopkins Chapel</u>	23d. LOCATION (City, town or county) (State) <u>Clarksville, Md</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Adolphus Halstead</u>		25a. REC'D BY REGISTRAR <u>1206 W North Ave</u>	
25b. REGISTRAR'S SIGNATURE <u>Adolphus Halstead</u>		25c. DATE <u>NOV 3 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS Page 5 may be retained for your files.

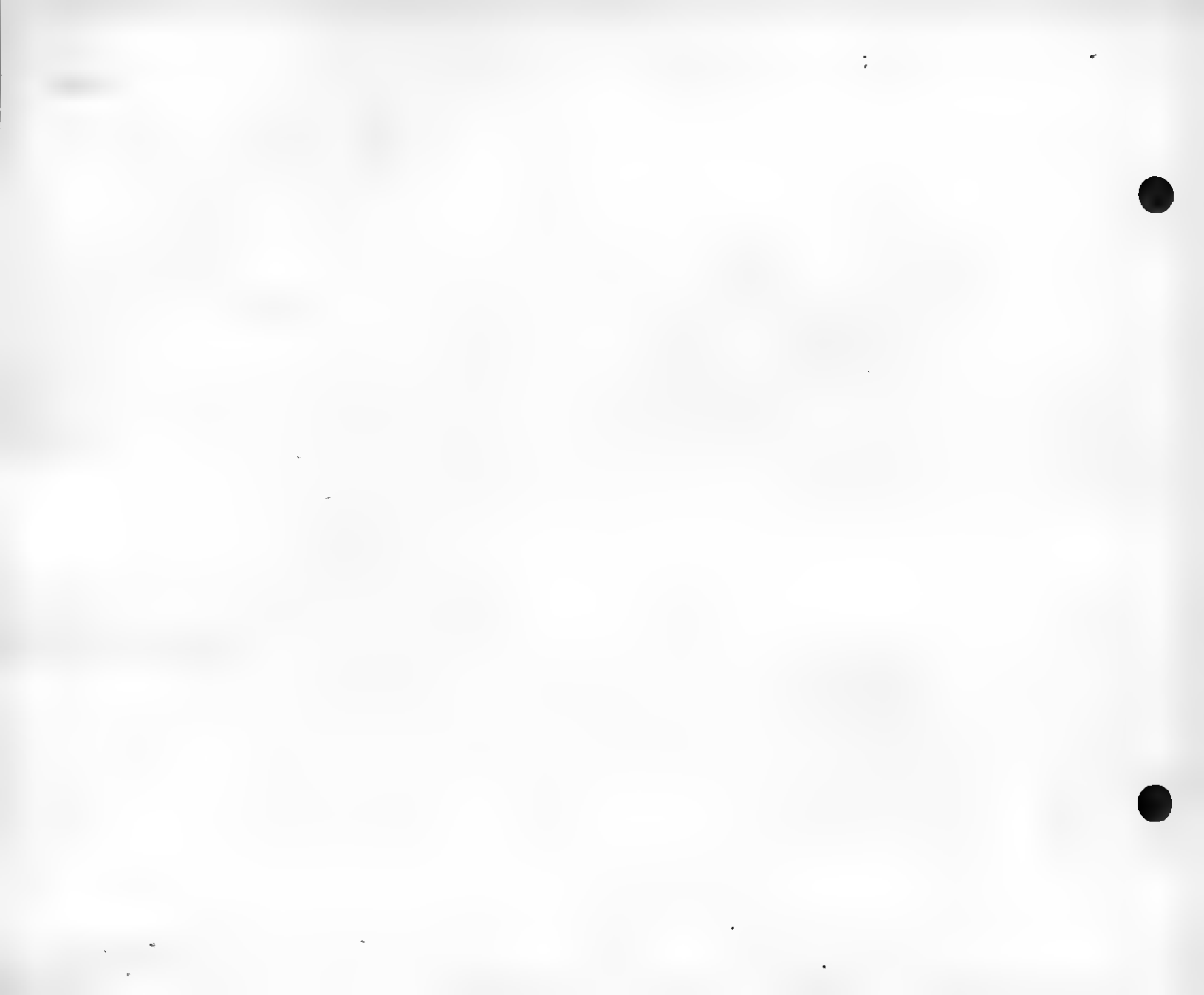
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY A.A. Co MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MO b. COUNTY AA CO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ocala	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. - Anne Arundel General L.		d. STREET ADDRESS RL 1 - Box 301	
3 NAME OF DECEASED (Type or print) Frederick A. Joeschke Sr.		4 DATE OF DEATH Month 11 Day 29 Year 1967	
5 SEX M	6 COLOR OR RACE W	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH April 23-1886
9 AGE (In years, most birthday) yrs 81		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED Wash. Navy yard	
10b. KIND OF BUSINESS OR INDUSTRY Washington, DC		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Joeschke		14. MOTHER'S MAIDEN NAME MARY Scherkler	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. Same as	
17. INFORMANT Ruth T. Smith (Daughter)		Address #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerosis, generalized DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, had an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE [Signature]		22. DATE SIGNED 11-29-67	
EXAMINER'S NAME (Type) Charles Judge		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASS STANT MED. CA. EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street city town or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Dec. 2nd, 1967	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Suitland, Maryland
24. FUNERAL DIRECTOR Simmons Bros.		25a. REC'D BY REGISTRAR DEC 1 1967	
ADDRESS 1661-Gd. Hope Rd. SE. Wash., DC		25b. REGISTRAR'S SIGNATURE [Signature]	



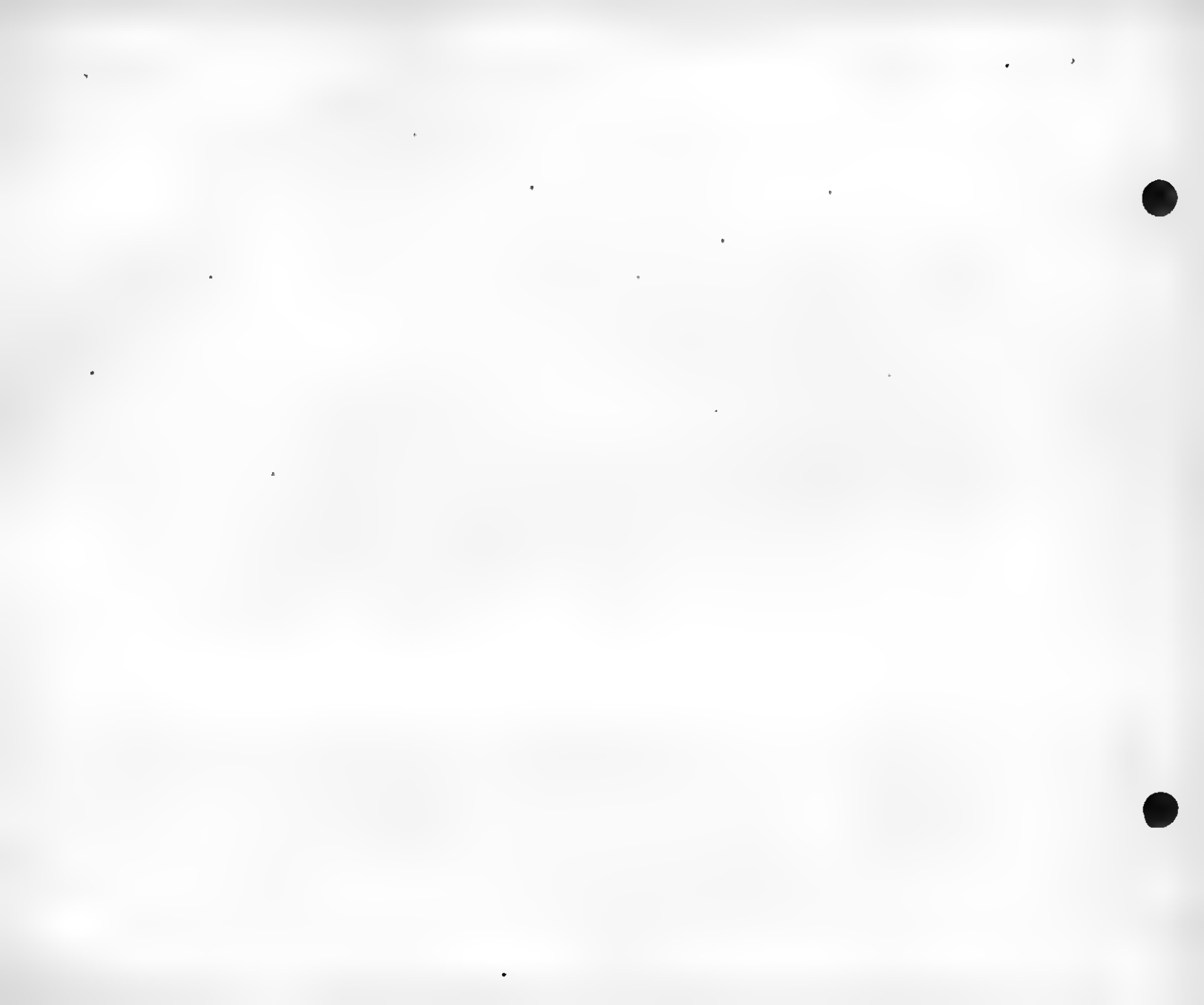
CERTIFICATE OF DEATH

14843

1. PLACE OF DEATH a. COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Md. b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b 24 Hrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hosp.		d. STREET ADDRESS 2802 Spindle Lane	
3. NAME OF DECEASED (Type or print) William H. Jahn, Sr.		4. DATE OF DEATH Nov. 26 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-13-79
9. AGE (In years last birthday) 87 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Watch Maker		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Omar F. Jahn		14. MOTHER'S MAIDEN NAME Isabelle Brazeale	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT William H. Jahn, Jr.		Address same as 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO <u>Sclerotic Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>Myocardial Damage</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Uremia</u>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/25/67 to 11/26/67 that (I) (we) last saw the deceased alive on 11/26/67, and that death occurred at 10:30 P.M. from causes and on the date stated above.			
22a. SIGNATURE Felix Gruenke		22b. DATED SIGNED 11/26/67	
22c. PHYSICIAN'S NAME (Type) Felix Gruenke		22d. ADDRESS 1113 Odessa Rd Odessa	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 30, 1967	
23c. NAME OF CEMETERY OR CREMATORY Pacific Cemetery		23d. LOCATION (City or Town) (County) (State) Pacific, Missouri	
24. FUNERAL DIRECTOR Kirkley Funeral Home, Glen Burnie, Md.		25a. REC'D BY REGISTRAR NOV 28 1967	
25b. REGISTRAR'S SIGNATURE J. M. Jones			

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



14935

CERTIFICATE OF DEATH

14844

1 PLACE OF DEATH a. COUNTY <i>Crownsville State Hospital</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admittance) a. STATE <i>MD.</i> b. COUNTY <i>An</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>CROWNSTOWN</i>		c. LENGTH OF STAY IN TB	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Crownsville State Hospital</i>		d. STREET ADDRESS <i>76 Summerfield Drive</i>	
3 NAME OF DECEASED (Type or print) First <i>Howard</i> Middle <i>G</i> Last <i>Jones</i>		4 DATE OF DEATH Month <i>11</i> Day <i>11</i> Year <i>1967</i>	
5. SEX <i>M</i>	6 COLOR OR RACE <i>W</i>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <i>11/9/15</i>
9 AGE (in years last birthday) <i>52</i> yrs		10 IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Wre house foreman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>STORAGE</i>	
11 BIRTHPLACE (County & State, or foreign country) <i>An. County</i>		12 CITIZEN OF WHAT COUNTRY? <i>US</i>	
13 FATHER'S NAME <i>Henry G. Jones</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Jones?</i>	
15 WAS DECEASED COVERED BY U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <i>YES 1944-47</i>		16 SOCIAL SECURITY NO.	
17 INFORMANT <i>wife Dorothy M. Jones</i>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Prognosis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) <i>Uremia</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (X) (this hospital) attended the deceased from <i>11/9/67</i> , 19 to <i>11/11/67</i> , 19, that (X) (we) last saw the deceased alive on <i>11/11/67</i> , 19, and that death occurred at <i>6:24</i> A.M. from causes and on the date stated above			
22a. SIGNATURE <i>L. Benedict M.D.</i>		22b. DATE SIGNED <i>11/11/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>L. BENEDICT M.D.</i>		22d. ADDRESS <i>Crownsville State Hospital</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <i>11/14-67</i>	23c. NAME OF CEMETERY OR CREMATORY <i>MAYO MEMORIAL</i>	23d. LOCATION (City or Town) (County) (State) <i>MAYO A.H. MD.</i>
24 FUNERAL DIRECTOR <i>John M. Taylor</i>		25a. REC'D BY REGISTRAR <i>NOV 15 1967</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14845

14836

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS		c. LENGTH OF STAY IN 1b ANNAPOLIS, MD.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) NAVAL HOSPITAL, ANNAPOLIS		d. STREET ADDRESS 2B Eucalyptus Rd.	
3. NAME OF DECEASED (Type or print) BABY GIRL JOSE		4. DATE OF DEATH Month NOV Day 2 Year 1967	
5. SEX Female	6. COLOR OR RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1 Nov. 1967
9. AGE (In years lost birthday) yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	
11. BIRTHPLACE (County & State, or foreign country) PHILLIPINES		12. CITIZEN OF WHAT COUNTRY? PHILLIPINES	
13. FATHER'S NAME JESUS BELBIS JOSE		14. MOTHER'S MAIDEN NAME LINDA NONE BAOL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO ---	
17. INFORMANT MOTHER		Address #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 176x Prematurity DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 18 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1 November, 1967 to 2 November 1967 , that (I) (we) last saw the deceased alive on 2 November 1967 , and that death occurred at 1255 M , from causes and on the date stated above.			
22a. SIGNATURE R. P. Killinger, M.D.		22b. DATE SIGNED 2 Nov. 1967	
22c. PHYSICIAN'S NAME (Type) R. P. KILLINGER, LCDR MC USN		22d. ADDRESS NAVAL HOSPITAL, ANNAPOLIS, MD.	
23a. BURIAL, CREMATION, OR REMOVAL (Specify)	23b. DATE THEREOF 11-3-67	23c. NAME OF CEMETERY OR CREMATORY U.S.N. ACADEMY	23d. LOCATION (City or Town) (County) (State) ANNAPOLIS MD
24. FUNERAL DIRECTOR John M. Taylor & Sons		25. REC'D BY REGISTRAR Charles Judge	
Address Duke of Gloucester St. Annapolis, Md.		DATE NOV 7 1967	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

14837

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16352

1 PLACE OF DEATH a COUNTY <u>Anne Arundel</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE <u>Maryland</u> b COUNTY <u></u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>			c LENGTH OF STAY IN lb <u>2 years</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>				d STREET ADDRESS <u>708 South Broadway</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>John Karsten</u>				4 DATE OF DEATH Month <u>11</u> Day <u>13</u> Year <u>1967</u>			
5. SEX <u>Male</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>9/5/10</u>		9 AGE (In years last birthday) <u>57</u> yrs	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS Hours <u></u> Min <u></u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shipping</u>		10b KIND OF BUSINESS OR INDUSTRY <u></u>		11 BIRTHPLACE (State or foreign country) <u>Nebraska</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Max Karsten</u>				14 MOTHER'S MAIDEN NAME <u>Margaret Karsten</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16 SOCIAL SECURITY NO <u>unknown</u>		17 INFORMANT <u>Hospital Records, Crownsville, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY <u>704.7</u> IMMEDIATE CAUSE (a) <u>Hypostatic Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Fat embolism</u> DUE TO (c) <u>Fracture of neck of left femur</u>						INTERVAL BETWEEN ONSET AND DEATH <u></u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Psychoneurotic Depressive Reactions; marked</u>						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Patient fell down in the bathroom</u>					
20c TIME OF INJURY Month, Day, Year Hour <u>8:25</u> a.m. <u>p.m.</u> <u>Nov. 4, 1967</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>Crownville St. Hos. Crownsville A.A. MD.</u>		20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>[Signature]</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22. DATE SIGNED <u>11-13-67.</u>		
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b DATE THEREOF <u>12-5-67</u>		23c NAME OF CEMETERY OR CREMATORY <u>University of Md.</u>		23d LOCATION (City or town) (County) (State) <u>Baltimore</u>	
24 FUNERAL DIRECTOR <u>Wm. D. Coe Mortuary 108 Annapolis, Md.</u>		25a REC'D BY REGISTRAR DATE <u>DEC 7 1967</u>		25b REGISTRAR'S SIGNATURE <u>[Signature]</u>			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14838

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14846

1 PLACE OF DEATH a COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a STATE <u>MD.</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>3 COMPROMISE ST</u>		d. STREET ADDRESS <u>3 COMPROMISE ST</u>	
3 NAME OF DECEASED (Type or print) <u>MARY DELL LEWIS KENWORTHY</u>		4 DATE OF DEATH Month <u>11</u> Day <u>27</u> Year <u>1967</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 AGE (In years last birthday) <u>87</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME</u>		11 BIRTHPLACE (State or foreign country) <u>MEDIA, Pa.</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>JOHN LEWIS</u>		14. MOTHER'S MAIDEN NAME <u>MARY DELL HILL</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>NO</u>		16 SOCIAL SECURITY NO <u>—</u>	
17 INFORMANT <u>GEORGE LEWIS JR. #2</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atherosclerosis, coronary</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o m p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>[Signature]</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. L. [Signature]</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street city, town, or county) <u>11/27/67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>11-30-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST. HELENE'S</u>	23d. LOCATION (City or Town) (County) (State) <u>ANNAPOLIS MD.</u>
24. FUNERAL DIRECTOR <u>John M. Taylor & Sons Annapolis, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 1 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



CERTIFICATE OF DEATH

14839

14847

1. PLACE OF DEATH a COUNTY ANNE ARUNDEL b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLEN BURNIE c LENGTH OF STAY IN b 3 MOS		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE MARYLAND b COUNTY BALTIMORE c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21222 d STREET ADDRESS 9 CENTRE AVE. e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last FLORENCE MABLE KERNER		4. DATE OF DEATH Month Day Year 11 11 1967	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-26-16
9. AGE (In years last birthday) 51 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SCHOOL BOARD		10b. KIND OF BUSINESS OR INDUSTRY BALTO CO. MD.	
11. BIRTHPLACE (County & State, or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? US IT	
13. FATHER'S NAME JOHN R. CAMPBELL		14. MOTHER'S MAIDEN NAME IDA JOHNSON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. ?	
17. INFORMANT JAYET WOOD		Address 9 CENTRE AVE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1561 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. DUE TO (b) Left Ventricular Failure DUE TO (c) Carcinoma of the liver		INTERVAL BETWEEN ONSET AND DEATH Months Weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Aug 11, 1967 to Nov 11, 1967 that (I) (we) last saw the deceased alive on Nov 11, 1967 , and that death occurred at 7:30 P.M. from causes and on the date stated above			
22a. SIGNATURE Max C Frank M.D.		22b. DATE SIGNED Nov 11/1967	
22c. PHYSICIAN'S NAME (Type) MAX C FRANK		22d. ADDRESS 4215 SE Ritchie Hwy. Glen Burnie MD 21061	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 11/14/67	23c. NAME OF CEMETERY OR CREMATORY OAK LAWN	23d. LOCATION (City or Town) (County) (State) BALTO, MD.
24. FUNERAL DIRECTOR J.G. CONNELLY SONS		25a. REC'D BY REGISTRAR NOV 15 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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12940

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14848

1. PLACE OF DEATH a. COUNTY Anne Arundel Co.		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillsmere Shores		c. LENGTH OF STAY IN b. MIDDLE		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town, Hillsmere Shores, Annapolis	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 506 Birch Drive		e. STREET ADDRESS 506 Birch Drive		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3. NAME OF DECEASED (Type or print) Lorraine B. Klever		4. DATE OF DEATH Nov. 9 1967		5. SEX female	
6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 14, 1884		9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired teacher		10b. KIND OF BUSINESS OR INDUSTRY public school		11. BIRTHPLACE (County & State, or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? US		13. FATHER'S NAME Norval L. Brady		14. MOTHER'S MAIDEN NAME Mary Evans	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 497-42-1748		17. INFORMANT Mrs. Mary Jone - same as #2 above		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral coronary occlusion</u> 7 days DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH minutes	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1965 to 11/9/67, that (I) (we) last saw the deceased alive on 11/9/67, and that death occurred at 11/9/67, from the causes and on the date stated above		22a. SIGNATURE Richard Peeler		22b. DATE SIGNED 11/5/67		22c. PHYSICIAN'S NAME (Type) Richard Peeler		22d. ADDRESS Cathedral St., Annapolis, Md.		22e. REC'D BY REGISTRAR DATE NOV 14 1967	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 13, 1967		23c. NAME OF CEMETERY OR CREMATORY Grandview Cemetery		23d. LOCATION (City, town or county) (State) Hannibal, Marion Co. Mo.		23e. REGISTRAR'S SIGNATURE Charles Judge		23f. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in on the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14841

CERTIFICATE OF DEATH

1449

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN IS 3hrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital		d. STREET ADDRESS 4132 Annapolis Rd., Apt. 2A	
3 NAME OF DECEASED (Type or print) First Charles Middle H. Last Knickman		4 DATE OF DEATH Month November Day 5 Year 19 67	
5 SEX M	6 COLOR OR RACE W	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-9-98
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Glass Blower (bottles) Md. Glass Corp.		10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Md.	12 CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME William Knickman		14. MOTHER'S MAIDEN NAME Anna Stonesifer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 213-01-0492-A	
17 INFORMANT Baltimore, address Md. 21227		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO PSHD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) atherosclerosis 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 min. p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 7, 1967 to 11/5/67 , 19 67 , that (I) (we) last saw the deceased alive on 11/3/67 , 19 67 , and that death occurred at 11/5/67 M, from causes and on the date stated above			
22a. SIGNATURE J.B. RAMIREZ		22b. DATE SIGNED 11/6/67	22c. PHYSICIAN'S NAME (Type) J.B. RAMIREZ
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/9/1967	23c. NAME OF CEMETERY OR CREMATORY Good Shepherd Cemetery
23d. LOCATION (City or Town) (County) (State) Ellicott City, Maryland		23e. REC'D BY REGISTRAR Charles Judge	
24 FUNERAL DIRECTOR Eastern Funeral Home		25a. DATE NOV 9 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14842

Item #7 Film G395 11/21/67 KK

CERTIFICATE OF DEATH

14830

1 PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MD.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN IS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Anne Arundel Gen Hosp</u>		d. STREET ADDRESS <u>Doris Dr. Arnold</u>	
3. NAME OF DECEASED (Type or print) <u>Francis Catherine Kootz</u> First Middle Last		4. DATE OF DEATH <u>11-11-67</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>70081892</u> 75
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (Country & State, or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Francis Ottavio Bilson</u>		14. MOTHER'S MAIDEN NAME <u>Groff</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u>214-03, 44639</u>	
17. INFORMANT <u>DORIS SMITH 2239 SOUTHLAND RD</u> Address		21207	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>H.C.V.D.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Gen art.</u> (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11-11-67</u> , 19 <u>67</u> to <u>11-11-67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11-11-67</u> , 19 <u>67</u> , and that death occurred at <u>6 P M</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Robert R. Halun</u> M.D.		22b. DATE SIGNED <u>11-11-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert R. Halun</u>		22d. ADDRESS <u>Severna Park Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>11/15/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LORRAINE PARK</u>	23d. LOCATION (City or Town) (County) (State) <u>BALTO MD</u>
24. FUNERAL DIRECTOR <u>J.T. STANSBURY 6411 WINDSOR MILL</u> ADDRESS		25a. REC'D BY REGISTRAR <u>NOV 15 1967</u> DATE	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

1
FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17843

11-51

1. PLACE OF DEATH

a. COUNTY

Anne Arundel

MARYLAND

b. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town)

c. LENGTH OF STAY N 1b

Glen Burnie

DOA

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

North Arundel Hospital

3. NAME OF DECEASED (Type or print)

Anna

M.

Lange

5. SEX

female

6. COLOR OR RACE

caus.

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

Nov. 30, 1889

9. AGE (in years last birthday)

77 yrs

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

ret. salesclerk

10b. KIND OF BUSINESS OR INDUSTRY

Stationary Store

11. BIRTHPLACE (State or foreign country)

Germany

12. CITIZEN OF WHAT COUNTRY?

Germany

13. FATHER'S NAME

Hector Friederich

14. MOTHER'S MAIDEN NAME

Schaus

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

16. SOCIAL SECURITY NO

17. INFORMANT

N/A

Mrs. Hilde McIntyre - same as #2 above

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

4500

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO

arteriosclerosis generalized

INTERVAL BETWEEN ONSET AND DEATH

sudden

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m.

20d. INJURY OCCURRED
While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

DATE SIGNED

11/19/67

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORY

22d. LOCATION (City, town, or country)

(State)

Burial

Nov. 22, 1967

Epiphany Cemetery

Odenton

Anne Arundel Md.

23. FUNERAL DIRECTOR

ADDRESS

Hopping Funeral Home - Annapolis, Md.

24a. REC'D BY REG. STRAR

24b. REGISTRAR'S SIGNATURE

NOV 22 1967

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon pages 1 and 2 and file them with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14844

14852

1 PLACE OF DEATH a. COUNTY AA MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MD b. COUNTY AG	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North Shore		c. LENGTH OF STAY IN 1b North Shore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 377 Dutchship Rd.		d. STREET ADDRESS 377 Dutchship Rd	
3 NAME OF DECEASED (Type or print) First STEVEN Middle LEVINSKI Last 1		4 DATE OF DEATH Month 11 Day 22 Year 1967	
5 SEX M	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH March 23, 1885
9a. AGE (in years last birthday) 82 yrs		9. AGE (in years last birthday) 82 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Boston Metal	
11 BIRTHPLACE (County & State, or foreign country) Poland		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME UNK		14 MOTHER'S MAIDEN NAME UNK	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16 SOCIAL SECURITY NO	
17 INFORMANT Truskey High		Address North Shore, Md	
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO (b) Generalized Arteriosclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 1 week 5 years
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) none			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18)	
20c. TIME OF INJURY Month Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat'l Wh <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from 6/4 , 19 63 , to 11/22 , 19 67 , that (I) (we) last saw the deceased alive on 11/17 , 19 67 , and that death occurred at 6:4 M, from causes and on the date stated above.			
22a. SIGNATURE R.M. McLaughlin		22b. DATE SIGNED 11/22/67	
22c. PHYSICIAN'S NAME (Type) R.M. McLaughlin		22d. ADDRESS 3708 Murcaton Rd. Pasadena, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11-25-67	23c. NAME OF CEMETERY OR CREMATORY Green Haven Cem	23d. LOCATION (City or Town) (County) (State) Green Borne Md
24. FUNERAL DIRECTOR J.H. Hahn		25a. REC'D BY REGISTRAR NOV 27 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14845

14853

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
				Baltimore			
d. NAME OF HOSPITAL, OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital				d. STREET ADDRESS 3606 West Bay Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CALVIN (mai) LIDIE, Jr.				4. DATE OF DEATH Month Day Year November 27, 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH April 21, 1923	9. AGE (In years last birthday) 44 yrs	10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Steel Industry		11. BIRTHPLACE (State or foreign country) Frederick County, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Calvin Lidie, Sr.				14. MOTHER'S MAIDEN NAME Margaret Lidie			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes W.W.#2		16. SOCIAL SECURITY NO 217 16 2548		17. INFORMANT Mrs. Naomi Lidie, Rt. 2, Frederick, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 9-11 IMMEDIATE CAUSE (a) Gunshot Wound of Abdomen DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) an apparent attempted robbery shot during					
20c. TIME OF INJURY Month, Day, Year 5:30 pm 11/27 1967		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Inn		20f. (City or town) (County) (State) Anne Arundel, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Werner U. Spitz		EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		22. DATE SIGNED 11/27/67		23. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 1, 1967		23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		23d. LOCATION (City or Town) (County) (State) Frederick, Maryland	
24. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Maryland				25a. REC'D BY REGISTRAR DEC 1 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14846

1454

1 PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>—</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c LENGTH OF STAY IN TB	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>		d STREET ADDRESS <u>833 Eutaw Street</u>	
3. NAME OF DECEASED (Type or print) <u>Adolf G. Markow</u>		4 DATE OF DEATH Month <u>11</u> Day <u>25</u> Year <u>1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/20/84</u>
9. AGE (In years last birthday) <u>83</u> yrs		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MANUFACTURER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ELECTRICAL</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Germany</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Adolf Markow</u>		14 MOTHER'S MAIDEN NAME <u>Augusta</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>066-100946</u>	
17. INFORMANT <u>Hospital Records, Crownsville, Maryland</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <u>493X</u> IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>1) Chronic Brain Syndrome 2) Hernia umbilical</u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>—</u> p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <u>8/1</u> , 1967, to <u>11/25</u> , 1967, that (I) (we) last saw the deceased alive on <u>11/25</u> 19 <u>67</u> , and that death occurred at <u>4:15</u> M, from causes and on the date stated above.			
22a SIGNATURE <u>[Signature]</u>		22b DATE SIGNED <u>11/25/67</u>	
22c PHYSICIAN'S NAME (Type) <u>Ludwig Benedict, M.D.</u>		22d ADDRESS <u>Crownsville State Hospital, Maryland</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b DATE THEREOF <u>11-29-67</u>	23c NAME OF CEMETERY OR CREMATORY <u>CEDAR BLUFF CEM.</u>	23d LOCATION (City or Town) (County) (State) <u>ANNAPOLIS MD</u>
24 FUNERAL DIRECTOR <u>JOHN M. TAYLOR & SONS ANNAPOLIS MD</u>		25a REC'D BY REGISTRAR <u>DEC 1 1967</u>	
		25b REGISTRAR'S SIGNATURE <u>[Signature]</u>	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MW3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14847

14855

1 PLACE OF DEATH a. COUNTY ANNAPOLIS Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived) a. STATE Maryland		b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY N 16		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 37 Oak Court		d. STREET ADDRESS 37 Oak Court		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) AKA Word Ward First White Middle White Last Martin		4. DATE OF DEATH November 30 19 67		Month November Day 30 Year 19 67	
5 SEX male	6 COLOR OR RACE Caus.	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH June 28, 1926	9 AGE (In years lost birthday) 41 yrs.	IF UNDER 1 YEAR Months 41 Days 41 Hours 41 Min. 41
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor		10b. KIND OF BUSINESS OR INDUSTRY Plastics		11 BIRTHPLACE (State or foreign country) Rose Hill, Va.	
13 FATHER'S NAME John H. Martin		14 MOTHER'S MAIDEN NAME Nancy Hopkins		12 CITIZEN OF WHAT COUNTRY? USA	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes WW II		16. SOCIAL SECURITY NO. 227-24-7114		17. INFORMANT Mrs. L. Fern Martin - same as #2 above	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY 716 X IMMEDIATE CAUSE (a) gun shot wound to chest DUE TO (b) gun shot wound to chest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) gun shot wound to chest		INTERVAL BETWEEN ONSET AND DEATH 11 30 67		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) gun shot wound to chest - self inflicted			
20c. TIME OF INJURY Month, Day, Year 11/30 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
20f. (City or town) ANNAPOLIS		20g. (County) ANNAPOLIS		20h. (State) MD	
21. I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE E. L. HAKOFF		M.D.		22. DATE SIGNED 11 30 67	
EXAMINER'S NAME (Type) E. L. HAKOFF		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town or county) ANNAPOLIS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/4/67		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery	
23d. LOCATION (City, town, county, state) Annapolis A.A. Md.		23e. REC'D BY REGISTRAR DEC 5 1967		23f. REGISTRAR'S SIGNATURE Charles Judge	
24 FUNERAL DIRECTOR HOPPING FUNERAL HOME * ANNAPOLIS, MD.		25 ADDRESS HOPPING FUNERAL HOME * ANNAPOLIS, MD.			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

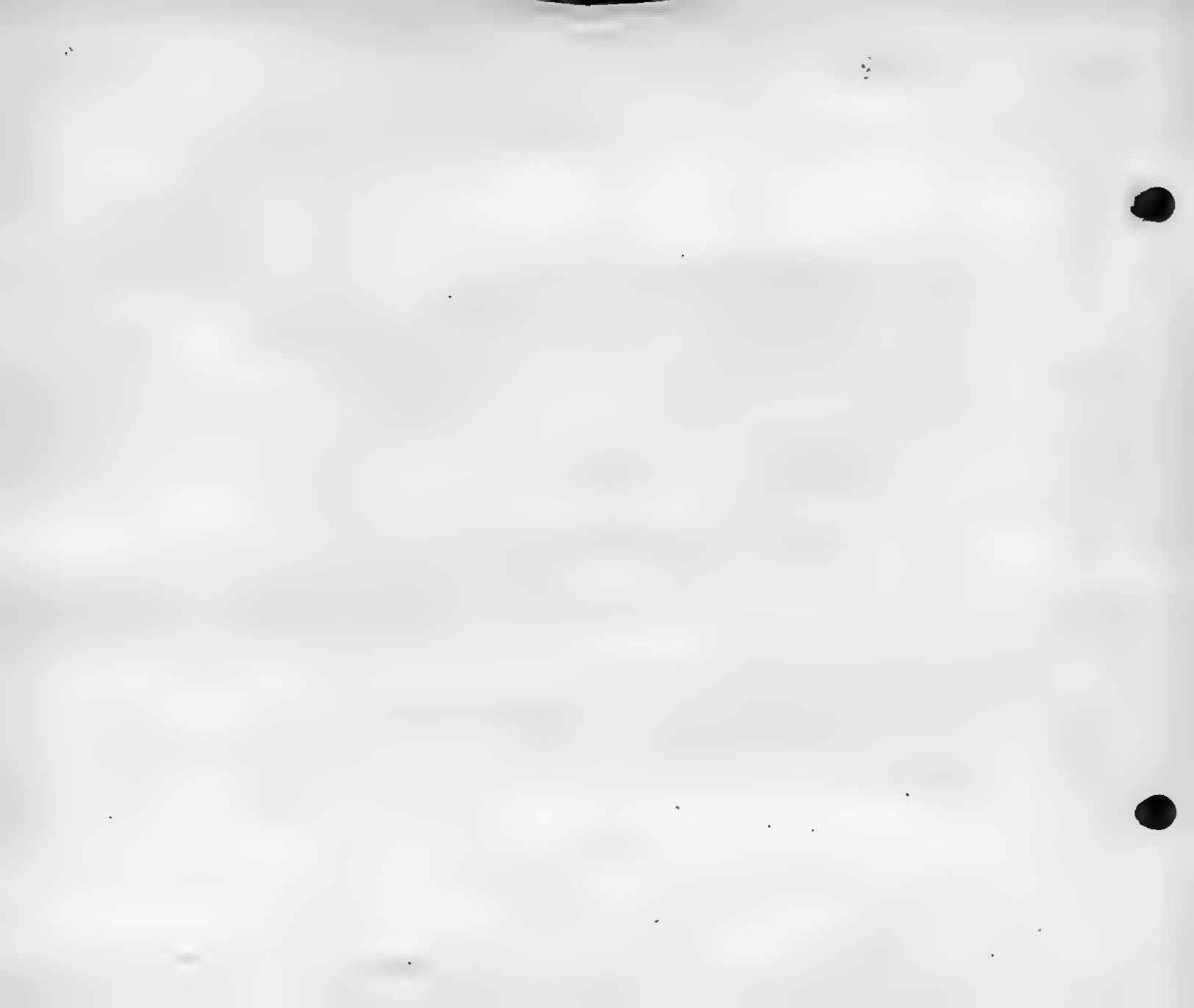
1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FT GEO G MEADE, MD c. LENGTH OF STAY IN ID 42 min d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kimbrough Army Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ft Geo G. Meade, Maryland d. STREET ADDRESS 7341-C Creed Court e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mc Clarnon, Infant Male		4. DATE OF DEATH Month November Day 4 Year 19 67	
5. SEX Male	6. COLOR OR RACE Cau	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4 Nov 67
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY N/A	9. AGE (In years last birthday) - yrs. 11. BIRTHPLACE (County & State, or foreign country) Anne Arundel, Maryland
13. FATHER'S NAME Terry L. Mc Clarnon		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) N/A		16. SOCIAL SECURITY NO. N/A	
17. INFORMANT Terry L. Mc Clarnon(f)		Address Same as # 2D	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary hypoplasia and Atelectasis 7590 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (if this hospital) attended the deceased from 4 Nov 1967 to 4 Nov 1967 , that (we) last saw the deceased alive on 4 Nov 67 19 and that death occurred at 11:40 AM from the causes and on the date stated above.			
22a. SIGNATURE Robert J. Cullen, M.D.		22b. DATE SIGNED 4 November 67	
22c. PHYSICIAN'S NAME ROBERT J. CULLEN, CPT, MC		22d. ADDRESS Kimbrough AH, Ft Geo G. Meade, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-8-67	
23c. NAME OF CEMETERY OR CREMATORY Long Hill		23d. LOCATION (City, town or county) (State) Laurel Md	
24. FUNERAL DIRECTOR De Witt Donaldson		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE NOV 13 1967	

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>AA 20</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA 20</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>AA 20</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RIVA MD</u>	
c. LENGTH OF STAY IN 1b <u>2 yrs</u>		d. STREET ADDRESS <u>5 H'out Rd Syva 5</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>724 ANDR</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>WIP ARE SMITH</u>	First Middle Last <u>Marlette</u>	4. DATE OF DEATH Month <u>10</u> Day <u>28</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/24/39</u>
9. AGE (In years last birthday) <u>68</u> yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NEWSPAPER</u>	11. BIRTHPLACE (County & State, or foreign country) <u>New York</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>RANDOLPH WRIGHT</u>	14. MOTHER'S MAIDEN NAME <u>Edith Moore</u>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>041-03-1054</u>		17. INFORMANT <u>DOROTHEA Marlette</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Metastatic adenocarcinoma</u> DUE TO (b) <u>Adenocarcinoma of bowel</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u>? 2 yrs.</u> <u>same.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 1965</u> to <u>Nov. 28, 1967</u> , that (I) (we) last saw the deceased alive on <u>Nov. 8, 1967</u> , and that death occurred at <u>10:30 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Barber C. Palmer Jr.</u>		22b. DATE SIGNED <u>11-28-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Barber C. Palmer Jr. M.D.</u>		22d. ADDRESS <u>121 Cathedral St. Annapolis, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY <u>LEE CREMATORY</u>	23d. LOCATION (City, town or county) (State) <u>WASHINGTON, D.C.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>T. H. ...</u>		25a. REC'D BY REGISTRAR <u>DEC 1 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



14850

CERTIFICATE OF DEATH

14858

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>441</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. LENGTH OF STAY IN 1b <u>2 mon</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Antol</u> Middle <u>Nemethvargo</u> Last <u>Nemethvargo</u>		4. DATE OF DEATH Month <u>11</u> Day <u>29</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/16/87</u>
9. AGE (in years last birthday) <u>80</u> YES <input type="checkbox"/> NO <input type="checkbox"/>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None Carpenter</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Hungary</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>213-12-3550A</u>	
17. INFORMANT <u>Hospital Records, Crownsville, Maryland</u>		18. ADDRESS <u>Unknown</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> DUE TO (b) <u>generalized Atherosclerosis</u> DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Urinary Tract Infection, Uremia Decubitus ulcers</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour <u>am</u> <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9/13</u> , 19 <u>67</u> , to <u>11/29</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>11/29</u> , 19 <u>67</u> , and that death occurred at <u>9:20</u> a.m. from causes and on the date stated above			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>11/29/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>L. Benedict, M.D.</u>		22d. ADDRESS <u>Crownsville State Hospital</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12/2/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Memorial Park</u>	23d. LOCATION (City or Town) (County) (State) <u>Howard Co. Maryland</u>
24. FUNERAL DIRECTOR <u>McCully Funeral Home</u>		25. REC'D BY REGISTRAR <u>DEC 4 1967</u>	
25a. ADDRESS <u>237 Patapsco Ave.</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

14851

CERTIFICATE OF DEATH

14859

1. PLACE OF DEATH a COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE MARYLAND b COUNTY ANNE ARUNDEL	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FT GEO & MEADE, MARYLAND		c LENGTH OF STAY IN 1b 12 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) KIMBROUGH ARMY HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EMMA NEUGEBAUER First Middle Last		4. DATE OF DEATH Month November Day 25 Year 67	
5. SEX F	6. COLOR OR RACE Cau	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11 FEB 1882
9. AGE (In years last birthday) 85 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY NONE	
11. BIRTHPLACE (County & State, or foreign country) GERMANY		12. CIT. ZEN. OF WHAT COUNTRY? GERMAN	
13. FATHER'S NAME THOMAS JAWORSKI		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO NONE	
17. INFORMANT EDELTRAUD JAMES (D)		Address Same as # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1547 IMMEDIATE CAUSE (a) Carcinoma of Rectum DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 13 Nov 67 to 25 Nov 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 25 Nov 1967 , and that death occurred at 0525 M, from causes and on the date stated above			
22a. SIGNATURE C. E. Jones, Jr.		22b. DATE SIGNED 25 Nov 67	
22c. PHYSICIAN'S NAME (Type) C. E. JONES, JR., OPT, MC		22d. ADDRESS KIMBROUGH AH FGGMM	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/28/67	23c. NAME OF CEMETERY OR CREMATORY Our Lady of Sorrows	23d. LOCATION (City or Town) (County) (State) Owensville A.A. Md.
25a. REC'D BY REGISTRAR DATE NOV 29 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN 1b Annopolis d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bristol 20728 d. STREET ADDRESS Bristol 20728 e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Greenwell First Middle Last OWENS		4. DATE OF DEATH November 24, 1967 Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 10, 1875 9. AGE (In years last birthday) yrs 92
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Carpenter	
11. BIRTHPLACE (County & State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 57824-9875A		16. SOCIAL SECURITY NO 57824-9875A	
17. INFORMANT Mrs. A. Fritz, Fairhaven, Md. Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) C. V. A. DUE TO (b) Hypertension, auricular fibrillation years DUE TO (c) Generalized arteriosclerosis years CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. — p.m. — 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 1966 to November 1967 , that (I) (we) last saw the deceased alive on 11/24 1967, and that death occurred at 11:35 A.M. M, from causes and on the date stated above.			
22a. SIGNATURE Charles H. Wirth MD M.D.		22b. DATE SIGNED 11/24/67	
22c. PHYSICIAN'S NAME (Type) Charles H. Wirth MD		22d. ADDRESS Lothian, Md 20820	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/27/67	23c. NAME OF CEMETERY OR CREMATORY Hope Chapel	23d. LOCATION (City or Town) (County) (State) Lothian, Md
24. FUNERAL DIRECTOR Richard F. and Helen, Greenfield, Md ADDRESS		25a. REC'D BY REGISTRAR DEC 12 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	

14853

CERTIFICATE OF DEATH

14860

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b Harwood	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		e. STREET ADDRESS Rt. 1, Box 140	
3. NAME OF DECEASED (Type or print) First James Middle Henry Last OWENS		4. DATE OF DEATH Month November Day 12 Year 1967	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 12, 1902
9. AGE (In years lost to rh/day) 65 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) General Manager		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME John Henry Owens		14. MOTHER'S MAIDEN NAME Elizabeth Randall	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 21830518	
17. INFORMANT Beauclerk Hall Anne Mc		18. ADDRESS	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY 157X IMMEDIATE CAUSE (a) Carcinoma of pancreas with DUE TO (b) metastases to liver DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH several months	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/6/67 , 19 11/12 , 1967 that (I) (we) last saw the deceased alive on 11/12/67 , 19 11/12 , 1967, and that death occurred at 6:45 A.M. from causes and on the date stated above			
22a. SIGNATURE Charles H. Wirth, MD		22b. DATE SIGNED 11/13/67	
22c. PHYSICIAN'S NAME (Type) Charles H. Wirth, MD		22d. ADDRESS Lothian, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-16-1967	
23c. NAME OF CEMETERY OR CREMATORY Chenoweth Memorial Cemetery		23d. LOCATION (City or Town) (County) (State) Chenoweth Md	
24. FUNERAL DIRECTOR William Reese		25a. REC'D BY REGISTRAR NOV 17 1967	
25b. REGISTRAR'S SIGNATURE William Reese		25c. REGISTRAR'S SIGNATURE William Reese	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14-61

14854

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <p style="text-align: center;">Anne Arundel</p>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <p style="text-align: center;">Maryland</p>		b. COUNTY <p style="text-align: center;">St. Mary's</p>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <p style="text-align: center;">Crownsville</p>		c. LENGTH OF STAY IN 1b <p style="text-align: center;">25 days</p>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <p style="text-align: center;">Colton</p>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <p style="text-align: center;">Crownsville State Hospital</p>				d. STREET ADDRESS <p style="text-align: center;">Rural Route</p>	
3. NAME OF DECEASED (Type or print) <p style="text-align: center;">Clarence Herbert Palmer Sr.</p>		4. DATE OF DEATH <p style="text-align: center;">11/29/1967</p>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <p style="text-align: center;">Male</p>		6. COLOR OR RACE <p style="text-align: center;">White</p>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <p style="text-align: center;">Nov. 27, 1889</p>		9. AGE (In years last birthday) <p style="text-align: center;">78 yrs</p>		10. UNDER 1 YEAR <input type="checkbox"/> 1 YEAR TO 24 HRS <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <p style="text-align: center;">Ret. Tavern Owner</p>		10b. KIND OF BUSINESS OR INDUSTRY <p style="text-align: center;">Self Employed</p>		11. BIRTHPLACE (County & State or foreign country) <p style="text-align: center;">Washington D.C.</p>	
12. CITIZEN OF WHAT COUNTRY? <p style="text-align: center;">USA</p>		13. FATHER'S NAME <p style="text-align: center;">William H. Palmer</p>		14. MOTHER'S MAIDEN NAME <p style="text-align: center;">Mary J. Sherwood</p>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <p style="text-align: center;">No</p>		16. SOCIAL SECURITY NO. <p style="text-align: center;">577-09-9069</p>		17. INFORMANT <p style="text-align: center;">Hospital Records, Crownsville, Maryland</p>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY <p style="text-align: center;">4200 Arteriosclerosis Heart Disease</p> IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> DUE TO (b) <u>Generalized Atherosclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <p style="text-align: center;">Hypertension, Diabetes Mellitus, Ulcer cellulitis of right leg, cirrhosis of liver</p>					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ pm 19 _____			
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11/4</u> , 19 <u>67</u> , to <u>11/29</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>11/29</u> , 19 <u>67</u> , and that death occurred at <u>1:30</u> P.M. from causes and on the date stated above					
22a. SIGNATURE <p style="text-align: center;">Ludwig Benedict, M.D.</p>		22b. DATE SIGNED <p style="text-align: center;">11/29/67</p>		22c. PHYSICIAN'S NAME (Type) <p style="text-align: center;">Ludwig Benedict, M.D.</p>	
22d. ADDRESS <p style="text-align: center;">Crownsville State Hospital, Maryland</p>		22e. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <p style="text-align: center;">Burial</p>		23b. DATE THEREOF <p style="text-align: center;">12/4/67</p>		23c. NAME OF CEMETERY OR CREMATORY <p style="text-align: center;">Ft. Lincoln</p>	
23d. LOCATION (City or Town) (County) (State) <p style="text-align: center;">Colmar Manor P/G. Md.</p>		24. FUNERAL DIRECTOR <p style="text-align: center;">Francis Gasch's Sons Hyattsville, Md.</p>			
25a. REC'D BY REGISTRAR DATE <u>DEC 5 1967</u>		25b. REGISTRAR'S SIGNATURE <p style="text-align: center;">Charles Judge</p>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14855

CERTIFICATE OF DEATH

14862

1 PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baymanor Nursing Home</u>		e. STREET ADDRESS <u>31 Bunchest St.</u>	
3. NAME OF DECEASED (Type or print) <u>Adison</u> First <u>Parker</u> Middle Last		4. DATE OF DEATH Month <u>11</u> Day <u>4</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-30-1940</u>
9. AGE (In years last birthday) <u>27</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Parker</u>		14. MOTHER'S MAIDEN NAME <u>Marjorie Addison</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Clarence Parker & Sonville</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 YEAR</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a.m. p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>12 OCT, 1967</u> to <u>4 NOV, 1967</u> that (I) (we) last saw the deceased alive on <u>3 NOV 1967</u> and that death occurred at <u>4P</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Edward Bear</u> M.D.		22b. DATE SIGNED <u>11-6-67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>11-8-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fairview</u>	23d. LOCATION (City or Town) (County) (State) <u>Edgewater MD</u>
24. FUNERAL DIRECTOR <u>William Rowett</u>		25a. REC'D BY REGISTRAR <u>DA NOV 7 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14856

14 63

1 PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN 1b Annopolis		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	
3 NAME OF DECEASED (Type or print) Adolph John PICKALL		4 DATE OF DEATH Month November Day 20 Year 1967	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 1, 1918
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY U.S. NAVAL RESERVE	
11 BIRTHPLACE (County & State or foreign country) Massachusetts		12 CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Pickall		14. MOTHER'S MAIDEN NAME Anna Pickall Jacobs	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes Ret.		16. SOCIAL SECURITY NO. 044-09-6607	
17. INFORMANT Mrs. Ruth Ann Pickall		Address 24 Thompson St. Anna., Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY 4201 IMMEDIATE CAUSE (a) Acute myocardial infarct DUE TO (b) Coronary artery disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) Heart		INTERVAL BETWEEN ONSET AND DEATH 7 weeks	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary embolism			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (as a physician) attended the deceased from Sept 20th , 19 67 , to Nov. 20 , 19 67 , that (I) (we) last saw the deceased alive on Nov. 20 , 19 67 , and that death occurred at 3:10 AM , from causes and on the date stated above.			
22a. SIGNATURE James E. Fisher		22b. DATE SIGNED 11/21/67	
22c. PHYSICIAN'S NAME (Type) GLADIA CHURCH		22d. ADDRESS 121 Cathedral St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Cremation	Nov. 24, 1967	Ft. Lincoln Cem.	Bladensburg Md.
24. FUNERAL DIRECTOR Beall Funeral Home		25a. REC'D BY REGISTRAR NOV 27 1967	
ADDRESS 1212 West St. Anna.		25b. REGISTRAR'S SIGNATURE Charles Jones	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

14857

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14864

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if not last residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 5 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 102 Riggs Ave.,	
3 NAME OF DECEASED (Type or print) (Caroline) Carrye Flagg		4 DATE OF DEATH Month November Day 29 Year 19 67	
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 5, 1888
9 AGE (In years, last birthday) 79 yrs		10. IF UNDER 1 YEAR Months 1 Days 29 Hours 19 Min 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11 BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William Flagg		14. MOTHER'S MAIDEN NAME Emma ----	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO.	
17 INFORMANT Frank Ralston		Address 102 Riggs Ave. - Severna Park, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal Shutdown DUE TO (b) alkalosis-dehydration & intestinal dist DUE TO (c) S.I.D. Malignant			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NAL DISEASE CONDITION GIVEN IN PART I (a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that (I) (X) deceased attended the deceased from 1960 , 19 Nov. 28, 1967 , that (I) (X) saw the deceased alive on Nov. 28, 19 67 , and that death occurred at 4:45 AM M, from causes and on the date stated above.			
22a SIGNATURE Robert R. Hahn		22b DATE SIGNED 11-29-67	
22c. PHYSICIAN'S NAME (Type) Robert R. Hahn, M.D.		22d. ADDRESS Box-73, Severna Park, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 12/4/67	23c NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Witzke F. D. - 4101 Edmondson Ave.		25a REC'D BY REGISTRAR DATE DEC 4 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14853

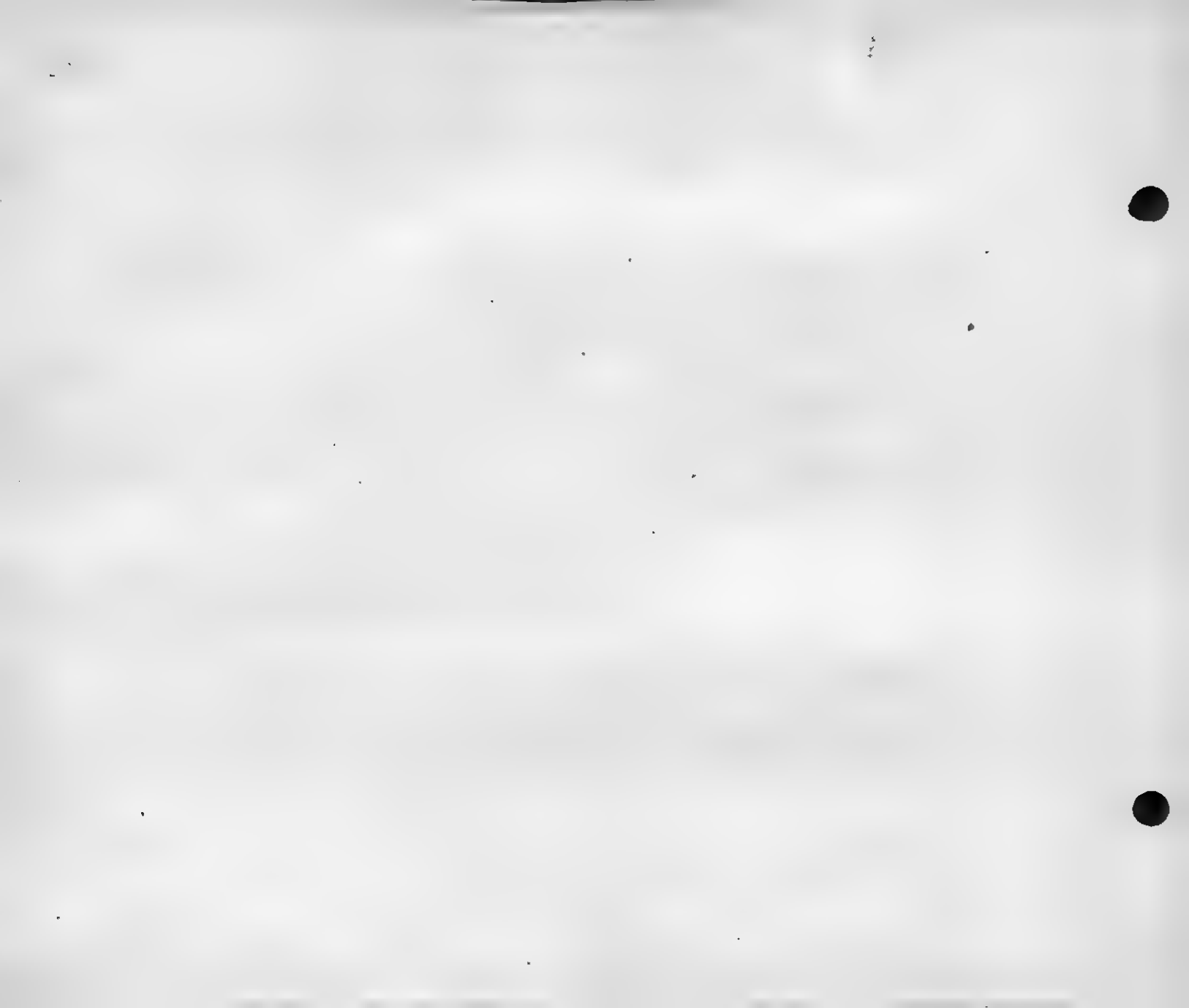
CERTIFICATE OF DEATH

14855

Item #1d Film #039511/23/67 ph

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Green Runie</u> c. LENGTH OF STAY IN b <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>NORTH</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severn</u> d. STREET ADDRESS <u>Box 60 Rt 2</u>			
3. NAME OF DECEASED (Type or print) <u>WILLIAM H. REYNOLDS</u>		4. DATE OF DEATH <u>NOV. 6 19 67</u>		5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 1, 1894</u>		9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR Months Days	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13. FATHER'S NAME <u>Arthur Reynolds</u>		14. MOTHER'S MAIDEN NAME <u>Matilda Stilling</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-28-6678</u>		17. INFORMANT <u>Herbert Reynolds - son same as #2 above</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Covering Thrombosis Aorta</u> (b) <u>Sclerotic Cardio Vascular</u> (c) <u>Heart</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10/5/58</u> to <u>11/7/67</u> that (I) (we) last saw the deceased alive on <u>11/7/67</u> and that death occurred at <u>11/7/67</u> M. from the causes and on the date stated above							
22a. SIGNATURE <u>[Signature]</u> M.D.				22b. DATE SIGNED <u>11/7/67</u>		22c. PHYSICIAN'S NAME (Type) <u>Frederick G. [Signature]</u>	
22d. ADDRESS <u>1115 Ocean Blvd. Ocean City</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/9/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Hopping Funeral Home - Annapolis, Md.</u>				25a. REC'D BY REGISTRAR <u>NOV 9 1967</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

14858

14866

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	
c. LENGTH OF STAY IN 1b Life		d. STREET ADDRESS 127 Janwall St.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) John Wesley RILEY		4 DATE OF DEATH Month November Day 17 Year 67	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH July 16, 1885
9 AGE (In years last birthday) 82 yrs		10 F UNDER 1 YEAR Months 1 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ret. grocer		10b. KIND OF BUSINESS OR INDUSTRY own business	
11 BIRTHPLACE (County & State or foreign country) Anne Arundel, Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.	
13 FATHER'S NAME George S. Riley		14. MOTHER'S MAIDEN NAME Jennie S. Goodwin	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO. 218-32-0427	
17. INFORMANT Robert K. Riley - same as #2 above		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Benign prostatic hypertrophy with marked arteriosclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Years		INTERVAL BETWEEN ONSET AND DEATH	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from Nov. 17, 1967 , to Nov. 17, 1967 , that (I) (we) last saw the deceased alive on Nov. 17, 1967 , and that death occurred at 7:30 AM from causes and on the date stated above			
22a. SIGNATURE Theodore G. Osius, Jr. M.D.		22b. DATE SIGNED 11-17-67	
22c. PHYSICIAN'S NAME (Type) Theodore G. Osius, Jr. M.D.		22d. ADDRESS 77 Franklin St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/20/67	
23c. NAME OF CEMETERY OR CREMATORY Cedar Bluff Cemetery		23d. LOCATION (City or town) (County) (State) Annapolis Md.	
24. FUNERAL DIRECTOR Beverley E. Hopping		25a. REC'D BY REGISTRAR NOV 21 1967	
HOPPING FUNERAL HOME - Annapolis, Md.		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14860

CERTIFICATE OF DEATH

14867

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riviera Beach c. LENGTH OF STAY IN 1b Riviera Beach d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) #265 Harlem Rd.		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riviera Beach d. STREET ADDRESS # 265 Harlem Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) RALPH RAYMOND RITTER First Middle Last		4. DATE OF DEATH November 5, 19 67 Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH April 19, 1905
9. AGE (In years last birthday) 62 yrs.		10. UNDER 1 YEAR Months Days	11. UNDER 24 HRS Hours Min
12a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder & Miner		12b. KIND OF BUSINESS OR INDUSTRY A. C. & F. Coal	
13. FATHER'S NAME William S. Ritter		14. MOTHER'S MAIDEN NAME Mary Geist	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No None		16. SOCIAL SECURITY NO 181-03-6215	
17. INFORMANT Mrs. William Kelly (Daughter)		Address Same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MASSIVE PNEUMOTHORAX DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) CHRONIC OBSTRUCTIVE PUL. EMPHYSEMA DUE TO (c) PNEUMOCONIOSIS (COAL MINER'S)		INTERVAL BETWEEN ONSET AND DEATH SUDDEN UNKNOWN UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CHRONIC BRONCHITIS DUE TO ANTHRACOSIS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from APRIL , 1966, to NOV , 1967, that (I) (we) last saw the deceased alive on NOV 3 , 1967, and that death occurred at 8:20 P.M. , from causes and on the date stated above.			
22a. SIGNATURE Arthur Lankford Jr.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) ARTHUR LANKFORD, JR., M.D.		22d. ADDRESS 2934 MOUNTAIN RD PASADENA, MD 21122	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Nov. 8, 1967	23c. NAME OF CEMETERY OR CREMATORY Pine Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Shickshinny, Penna.
24. FUNERAL DIRECTOR Singleton Funeral Home		25a. REC'D BY REGISTRAR Glen Burnie, Md.	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE NOV 7 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers, Pages 7 and 8, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

14861

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14868

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital				d. STREET ADDRESS 10 Constitution Ave.		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Joseph Middle Anthony Last ROSATI				4. DATE OF DEATH Month November Day 12 Year 1967			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 27, 1901	
9. AGE (In years last birthday) 66 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GUARD		10b. KIND OF BUSINESS OR INDUSTRY State of Md. PHOEBUS, Virginia		11. BIRTHPLACE (County & State, or foreign country) U. S.	
12. CITIZEN OF WHAT COUNTRY? U. S.				13. FATHER'S NAME Joseph Rosati			
14. MOTHER'S MAIDEN NAME Filipia DEKIA				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WWI			
16. SOCIAL SECURITY NO				17. INFORMANT Mary Rosati Address #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Meningeal cerebral aneurysm DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June , 19 63 , to Nov. , 19 67 that (I) (we) last saw the deceased alive on Nov. 11 , 19 67 , and that death occurred at 10:28 M, from causes and on the date stated above.							
22a. SIGNATURE John L. Hedeman M.D.				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) John L. Hedeman M. D.				22d. ADDRESS 1407 Forest Drive, Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11-15-67		23c. NAME OF CEMETERY OR CREMATORY St. Mary's		23d. LOCATION (City or town) (County) (State) Annapolis Md.	
24. FUNERAL DIRECTOR John McLaughlin & Sons				25a. REC'D BY REGISTRAR NOV 15 1967			
25b. REGISTRAR'S SIGNATURE Charles Judge							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2, and in any event, within 72 hours after death should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>A.A.Co</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: <u>MD.</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Anne Arundel Health Center</u>		d. STREET ADDRESS <u>10 HICKS AVENUE</u>	
3. NAME OF DECEASED (Type or print) <u>Eugene Thomas Ross</u>		4. DATE OF DEATH Month <u>11</u> Day <u>4</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 7-1903</u> 64 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Self-employed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>ANNAPOLIS</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John R. Ross</u>		14. MOTHER'S MAIDEN NAME <u>Emma Thomas</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>110-07-3724</u>	
17. INFORMANT <u>Ethel J. Ross</u>		Address <u>195 CLAY ST. ANNA-MD</u>	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> DUE TO <u>Severe Arterio</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Probable G.I. Malignancy</u> (c) <u>—</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour <u>—</u> a.m. <u>—</u> p.m. 19 <u>67</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11-3-67</u> , 19 <u>67</u> to <u>11-4-67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11-4-67</u> , 19 <u>67</u> , and that death occurred at <u>12 PM</u> , from causes and on the date stated above.			
22a SIGNATURE <u>Robert R. HAHW</u>		22b DATE SIGNED <u>NOV 9 1967</u>	
22c PHYSICIAN'S NAME (Type) <u>Robert R. HAHW</u>		22d ADDRESS <u>P.O. BOX 73 Severna Park</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b DATE THEREOF <u>11-8-1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>	23d LOCATION (City or Town) (County) (State) <u>ANNAPOLIS A.A.Co Md.</u>
24. FUNERAL DIRECTOR <u>C.E. HALL'S ANNAPOLIS, MD</u>		25a REC'D BY REGISTRAR <u>NOV 9 1967</u>	25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>

CERTIFICATE OF DEATH

14670

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) FT GEO G MEADE		c. LENGTH OF STAY IN lb 1 hr 52 min	c. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) LAUREL
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) KIMBROUGH ARMY HOSPITAL		d. STREET ADDRESS 204 6th STREET	
3. NAME OF DECEASED (Type or print) INFANT BOY SCOTT		4. DATE OF DEATH Month NOVEMBER Day 13 Year 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV 13, 1967
9. AGE (In years last birthday) yrs 1		10. IF UNDER 1 YEAR Months 1 Days 56	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY N/A	11. BIRTHPLACE (County & State, or foreign country) Anne Arundel, Md
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME LEROFY F. SCOTT, JR.	
14. MOTHER'S MAIDEN NAME REGINA C. SUSSMEIER		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO N/A		17. INFORMANT (father) Address Leroy F. Scott, Jr. (same as Item #2)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY ATELECTASIS DUE TO PREMATURITY Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from 13 Nov , 19 67 , to 13 Nov , 19 67 , that (we) saw the deceased alive on 13 Nov , 19 67 , and that death occurred at 5:00p M, from causes and on the date stated above.			
22a. SIGNATURE Robert F. Cullen Jr.		22b. DATE SIGNED 13 NOV 67	
22c. PHYSICIAN'S NAME (Type) ROBERT F. CULLEN, JR. CPT, MC		22d. ADDRESS KIMBROUGH ARMY HOSP, FT GEO G MEADE, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Nov. 16 1967	23c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem	23d. LOCATION (City or Town) (County) (State) Arlington Va.
24. FUNERAL DIRECTOR W.W. Chamber & Riverside Md		25a. REC'D BY REGISTRAR DATE NOV 17 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, with in 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park, Md.</u>	
c. LENGTH OF STAY IN lb <u>1 day</u>		d. STREET ADDRESS <u>310 Holland Road,</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Anne Arundel Gen. Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Carol</u> Middle <u>Ann</u> Last <u>Sewell</u>		4. DATE OF DEATH Month <u>11</u> Day <u>19</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/17/67</u>
9. AGE (In years lost birthday) <u>0 yrs</u>		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>48</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Newborn</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State) or foreign country <u>Maryland Anne Arundel</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William F. Sewell</u>		14. MOTHER'S MAIDEN NAME <u>Carol Howell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>n/a</u>		16. SOCIAL SECURITY NO. <u>_____</u>	
17. INFORMANT <u>Hospital records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) - PART I. DEATH WAS CAUSED BY. <u>776 X</u> IMMEDIATE CAUSE (a) <u>Prematurity</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>_____</u> DUE TO (c) <u>_____</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>_____</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>_____</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <u>(the hospital)</u> attended the deceased from <u>11/19, 1967</u> , to <u>11/19, 1967</u> that (I) <u>did</u> not see the deceased alive on <u>11/19, 1967</u> and that death occurred at <u>9:15 AM</u> , from causes and on the date stated above			
22a. SIGNATURE <u>Jonathan M. Sutton</u>		22b. DATE SIGNED <u>11/19/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Jonathan M. Sutton, M.D.</u>		22d. ADDRESS <u>201 Forbes St., Annapolis, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/21/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemetery</u>		23d. LOCATION (City or town) (County) (State) <u>Glen Burnie, A. A. Md.</u>	
24. FUNERAL DIRECTOR <u>Raymond C. Fink</u>		25a. REC'D BY REGISTRAR <u>NOV 22 1967</u>	
ADDRESS <u>Glen Burnie, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

14865

CERTIFICATE OF DEATH

14872

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before adm ssion) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Revell Highway		c. LENGTH OF STAY IN lb Owings	
d. NAME OF HOSPITAL OR INST TUTION (f not in hospita, give street address) Bay Manor Nursing Home		d. STREET ADDRESS Owings	
3. NAME OF DECEASED (Type or print) ETHEL REBECCA SHIFFLET		4. DATE OF DEATH Month November Day 27 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 4, 1901
9. AGE (In years last birthday) 66 yrs		10. FUND 1 YEAR Months 27 Days 27 Hours 27 Min 27	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Calvert Co., Maryland	
11. BIRTHPLACE (County & State, or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joshua L. Sears		14. MOTHER'S MAIDEN NAME Mary K. Taylor	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Woodrow Shifflet Owings, Maryland	
17. INFORMANT Woodrow Shifflet Owings, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic Cerebral Disease DUE TO (b) Carcinoma of breast DUE TO (c) unknown		INTERVAL BETWEEN ONSET AND DEATH unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/13 , 1967, to 11/27 , 1967, that (I) (we) last saw the deceased alive on 11/13 , 1967, and that death occurred at 120P M, from causes and on the date stated above			
22a. SIGNATURE Richard I. Hochman M.D.		22b. DATE SIGNED 11/27/67	
22c. PHYSICIAN'S NAME (Type) Richard I. Hochman, MD		22d. ADDRESS 16 Murray Avenue, Annapolis, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 30, 1967	
23c. NAME OF CEMETERY OR CREMATORY So. Memorial Gardens		23d. LOCATION (City or town) (County) (State) Dunkirk Calvert Md.	
24. FUNERAL DIRECTOR Fletcher Funeral Home		25a. REC'D BY REGISTRAR DEC 1 1967	
25b. REGISTRAR'S SIGNATURE John J. Jones			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

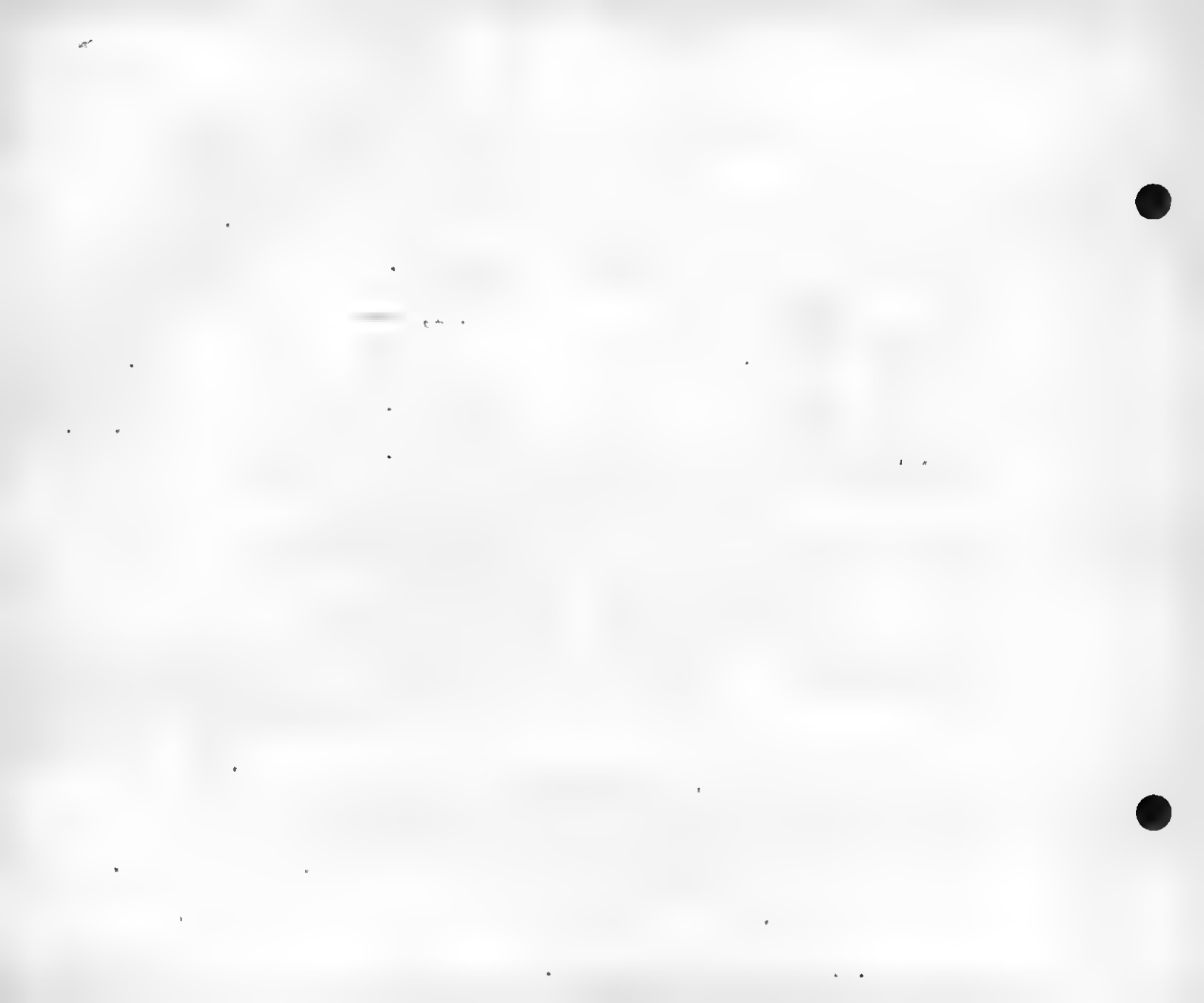
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

<div> <div>14866</div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>Item 3 Film 8/8/66 kk</div> </div> <div>14873</div> </div> <div>CERTIFICATE OF DEATH</div>									
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital					d. STREET ADDRESS 135 Eastern Ave.,				
3. NAME OF DECEASED (Type or print) Charles Edward Smith, Jr.					4. DATE OF DEATH Month November Day 2 Year 1967				
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 1, 1900		9. AGE (In years last birthday) 67 yrs IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Cook U.S. Naval Academy			10b. KIND OF BUSINESS OR INDUSTRY U.S. Naval Academy		11. BIRTHPLACE (County & State or foreign country) Annapolis Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Frank Smith					14. MOTHER'S MAIDEN NAME Mary E. Brown				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW1			16. SOCIAL SECURITY NO. 218-26-5090		17. INFORMANT Charlotte J. Smith-135 Eastern Ave. Annapolis, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Coronary atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Coronary atherosclerosis DUE TO Coronary atherosclerosis (c) Coronary atherosclerosis								INTERVAL BETWEEN ONSET AND DEATH Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> 19 <input type="checkbox"/>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (the hospital) attended the deceased from <u>6/24, 1964</u> to <u>Nov. 2, 1967</u> that (I) (the hospital) saw the deceased alive on <u>Nov. 2, 1967</u>, and that death occurred at <u>Nov. 2, 1967</u> M, from causes and on the date stated above.								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
22a. SIGNATURE R.I. Hochman, M.D.					22b. DATE SIGNED 11/3/67		22c. PHYSICIAN'S NAME (Type) R.I. Hochman, M.D.		
22d. ADDRESS 16 Murray Ave., Annapolis, Md.					22e. DATE SIGNED 11/3/67				
23a. BURIAL, CREMATION, or other disposal (Specify) Burial			23b. DATE THEREOF Nov. 6-67		23c. NAME OF CEMETERY OR CREMATORY St Annes			23d. LOCATION (City or town) (County) (State) Annapolis, Md.	
24. FUNERAL DIRECTOR C.E. Hicks III Annapolis, Md.					25a. REC'D BY REGISTRAR NOV 9 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VR A15 (4-67)
25M 1/67

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14867

14874

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shady Side	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS Shady Side	
3 NAME OF DECEASED (Type or print) Howard Emerson STALLINGS		4 DATE OF DEATH Month November Day 25 Year 1967	
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 9, 1900
9 AGE (In years last birthday) 66 yrs		10 UNDER 1 YEAR IF UNDER 24 HRS Months 6 Days 18 Hours 0 Min 0	
10a. US. AL. OCCUPATION (Give kind of work done during most of working life, even if retired) Plumbing Inspector		10b. KIND OF BUSINESS OR INDUSTRY P.A. Co. Md. P.A. Co., Maryland	
11 BIRTHPLACE (County & State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.	
13 FATHER'S NAME AMES W. Stallings		14 MOTHER'S MAIDEN NAME ELIZABETH Cwings	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16 SOCIAL SECURITY NO. 216 18 5901	
17 INFORMANT Lucy M. Stallings		Address #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar pneumonia DUE TO (b) Chronic congestive heart failure DUE TO (c) Arteriosclerotic ht. disease & myocardial infarction, mural thrombosis & endocardial fibrosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4201			
INTERVAL BETWEEN ONSET AND DEATH 48 hours several years several years			
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour "a.m." 19 p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan , 1962, to Nov. 25 , 1967, that (I) (we) lost saw the deceased alive on Nov. 24 1967, and that death occurred at 8:10 AM from causes and on the date stated above			
22a SIGNATURE Willard F. Smith		22b DATE SIGNED 11/25/67	
22c PHYSICIAN'S NAME (Type) Willard F. Smith MD		22d ADDRESS Shady Side, Maryland	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF 11-28-67	23c NAME OF CEMETERY OR CREMATORY QUAKER Burying Ground	23d LOCATION (City or Town) (County) (State) West River H.A. MD.
24 FUNERAL DIRECTOR John M. Lyons		25a REC'D BY REGISTRAR NOV 28 1967	
25b REGISTRAR'S SIGNATURE Annapolis, Md.			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14868

14875

1 PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>616 Oakdale Circle</u>		d. STREET ADDRESS <u>616 Oakdale Circle</u>	
3 NAME OF DECEASED (Type or print) <u>Catherine A. Stouffer</u>		4 DATE OF DEATH Month <u>Nov.</u> Day <u>13</u> Year <u>1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12 18 1910</u>
9 AGE (In years last birthday) <u>55</u> yrs		10 IF UNDER 1 YEAR Months <u>6</u> Days <u>11</u> Hours <u>14</u> Min. <u>57</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher-Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Schools</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Louis Schmidt</u>		14. MOTHER'S MAIDEN NAME <u>Anna Heimel</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-05-2076</u>	
17. INFORMANT <u>Mr. Paul D. Stouffer</u>		Address <u>Same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>General carcinomatosis</u> DUE TO (b) <u>Carcinoma of left breast</u> DUE TO (c) <u>11/13/67</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>3 1/2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>no.</u>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>-</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>May 7,</u> 19 <u>57,</u> to <u>Novem. 13</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Nov. 9,</u> 19 <u>67,</u> and that death occurred at <u>10:00 A.M.</u> on the date stated above.			
22a. SIGNATURE <u>C. C. Chiu</u>		22b. DATE SIGN'D <u>11-14-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>C. C. CHIU, M. D.</u>		22d. ADDRESS <u>1 E. Randall St. Baltimore Md 21230</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>11 16 67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Madowridge</u>		23d. LOCATION (City or Town) (County) (State) <u>Dorsey, Md.</u>	
24. FUNERAL DIRECTOR <u>J. C. Gully</u>		25a. REC'D BY REGISTRAR <u>NOV 15 1967</u>	
ADDRESS <u>130 W. Port Ave</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



CERTIFICATE OF DEATH

14868

14876

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 2 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS Box 126	
3 NAME OF DECEASED (Type or print) William Henry SWITZER		4 DATE OF DEATH Month November Day 24 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 12, 1896
9. AGE (In years, months, days) 70 yrs		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED MACHINIST		10b. KIND OF BUSINESS OR INDUSTRY B. & O. RAILROAD	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME SAMUEL SWITZER		14. MOTHER'S MAIDEN NAME MARY JOSEPHINE LAWRENCE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 214-09-2251	
17. INFORMANT MR. JEAN W. SHOWE, BOX 126, ARNOLD, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hepatic coma DUE TO Gastrointestinal hemorrhage 2 days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Carcinomatosis (hepatic) DUE TO 3 years		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Postnecrotic cirrhosis, arteriosclerotic cardiovascular disease, Pulmonary emphysema, Suspected primary carcinoma of pancreas		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 20, 1967 , to Nov 24, 1967 , that (I) (we) last saw the deceased alive on Nov 24, 1967 , and that death occurred at 1:00 P.M. from causes and on the date stated above.			
22a. SIGNATURE Charles W. Kinzer		22b. DATE SIGNED Nov 24, 1967	
22c. PHYSICIAN'S NAME (Type) Charles W. Kinzer, M. D.		22d. ADDRESS 16 Murray Avenue, Annapolis, Maryland 21401	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 11/27/67	23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY	23d. LOCATION (City or Town) (County) (State) HAGERSTOWN, WASH. CO. MD.
24. FUNERAL DIRECTOR CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.		25a. REC'D BY REGISTRAR NOV 30 1967	
		25b. REGISTRAR'S SIGNATURE W. J. Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14877

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>A.A. CO.</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a STATE <u>MD</u> b COUNTY	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Green BURNIE</u>		c LENGTH OF STAY In <u>Baltimore - 26 - mch</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.M. - NORTH. ARNOLD - Hosp. 1st L</u>		d STREET ADDRESS <u>140-9 Greenland Beach Rd</u>	
3 NAME OF DECEASED (Type or print) <u>FRANK SZMAJDA</u>		4 DATE OF DEATH Month <u>11</u> Day <u>8</u> Year <u>1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>8-2-17</u>
9 AGE (In years lost birthday) <u>50</u> YES		10 IF UNDER 1 YEAR Months <u>11</u> Days <u>8</u> Hours <u>19</u> Min <u>67</u>	
11b USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Office Manager</u>		11b KIND OF BUSINESS OR INDUSTRY <u>Construction Ind.</u>	
11 BIRTHPLACE (State or foreign country) <u>Balto., Md.</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frank Szmaida</u>		14 MOTHER'S MAIDEN NAME <u>Laura Pelmanowski</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>220-14-9058</u>	
17. INFORMANT <u>Mrs Frank M. Szmaida</u>		Address <u>21226</u> <u>140 Greenland Beach Rd.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac disease</u> <u>4344</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH <u>Hidden</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>[Signature]</u> M.D.		22 DATE SIGNED <u>11-8-67</u>	
EXAMINER'S NAME (Type) <u>ELIN HART</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street city town or county)	
23a BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>11-13-1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cem</u>	23d LOCATION City Town (County) (State) <u>Balto., Md.</u>
24 FUNERAL DIRECTOR <u>Wm. Cook-Brooks, Inc. 1217 St. Paul St. Balto.</u>		25a RECEIVED BY REGISTRAR <u>NOV 13 1967</u>	
ADDRESS		25b REGISTRAR'S SIGNATURE <u>[Signature]</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14878

14871

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 1413 Poplar St.,	
3 NAME OF DECEASED (Type or print) Emma Helen TAYLOR		4 DATE OF DEATH Month November Day 1 Year 19 67	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 28, 1886
9 AGE (In years lost birthday) yrs 81		10 UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Elizabeth, New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Martin Kramer		14. MOTHER'S MAIDEN NAME Wilhelmina Kramer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 216-24-6313	
17. INFORMANT Mrs. Robert Beall Sr.		Address 1413 Poplar St. Annapolis, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) congestive heart failure DUE TO (b) cardio myopathy of undetermined cause DUE TO (c) 4344 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 4 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (we) attended the deceased from August , 19 66 , to Nov. 1 , 19 67 , that (I) (we) last saw the deceased alive on Nov. 1 , 19 67 , and that death occurred at 7:40 PM M, from causes on and on the date stated above.			
22a. SIGNATURE R. Beall		22b. DATE SIGNED 11/2/67	
22c. PHYSICIAN'S NAME (Type) Anna		22d. ADDRESS 121 Cathedral St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Nov. 4, 1967	23c. NAME OF CEMETERY OR CREMATORY Asbury Meth Ch Cem	23d. LOCATION (City or Town) (County) (State) Arnold Md.
24. FUNERAL DIRECTOR Beall Funeral Home		25. REC'D BY REGISTRAR Anna. Md.	
25b. REGISTRAR'S SIGNATURE R. Charles Judge		DATE NOV 6 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 is to be retained by the hospital or attending physician. Page 2 is to be retained by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
14872									
14879									
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>AA</u>				
b. CITY OR TOWN (if outside of corporate limits, write RURAL and give nearest town) <u>Annapolis</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>AA General Hospital</u>					d. STREET ADDRESS <u>3 Altoona Avenue</u>				
3. NAME OF DECEASED (Type or print) <u>OLIVE</u>					4. DATE OF DEATH Month <u>Nov</u> Day <u>10</u> Year <u>1967</u>				
5. SEX <u>Female</u>					6. COLOR OR RACE <u>White</u>				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <u>24 Sept. 1887</u>				
9. AGE (In years last birthday) <u>80</u> yrs.					10. IF UNDER 1 YEAR Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>				
11. BIRTHPLACE (County & State, or foreign country) <u>AA County, Maryland</u>					12. CITIZEN OF WHAT COUNTRY <u>USA</u>				
13. FATHER'S NAME <u>William Watts</u>					14. MOTHER'S MAIDEN NAME <u>Lydia Stinchcomb</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u>					16. SOCIAL SECURITY NO. 17. INFORMANT <u>Mrs. Erma Moles, same as 2</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MASSIVE CEREBRAL HEMORRHAGE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO (c) <u>ARTERIOSCLEROTIC HEART DISEASE</u>					INTERVAL BETWEEN ONSET AND DEATH <u>72 HRS</u> <u>MORE THAN 10 YRS.</u>				
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 1B)				
20c. TIME OF INJURY Hour <u>a.m.</u> Month, Day, Year <u>19</u>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (the hospital) attended the deceased from <u>APRIL 19, 1963</u> to <u>NOV 10, 1967</u> , that (I) (we) last saw the deceased alive on <u>NOV 9, 1967</u> , and that death occurred at <u>11 AM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Arthur Lankford Jr.</u>					22b. DATE SIGNED <u>11-10-67</u>				
22c. PHYSICIAN'S NAME (Type) <u>ARTHUR LANKFORD, JR., M. D.</u>					22d. ADDRESS <u>2934 MOUNTAIN RD PASADENA, MD 21122</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>					23b. DATE THEREOF <u>13 Nov. 67</u>				
23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial</u>					23d. LOCATION (City, town or county) (State) <u>Glen Burnie, Maryland</u>				
24. FUNERAL DIRECTOR'S SIGNATURE <u>Girkey Funeral Home, Glen Burnie, Md.</u>					25a. REC'D BY REGISTRAR <u>NOV 14 1967</u>				
					25b. REGISTRAR'S SIGNATURE <u>Thomas J. Justice</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VII A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. LENGTH OF STAY IN TB <u>5 months</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>		e. STREET ADDRESS <u>3004 Larue Street</u>	
3 NAME OF DECEASED (Type or print) <u>Odessa L. Whitfield</u>		4. DATE OF DEATH <u>11 6 19 67</u>	
5 SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>12/19/05</u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>North Carolina</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Richard King</u>		14. MOTHER'S MAIDEN NAME <u>Laura Dawson</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16 SOCIAL SECURITY NO <u>unknown</u>	
17. INFORMANT <u>Hospital Records, Crownsville, Maryland</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Uremia</u>			
DUE TO (b) <u>Arteriosclerotic cardio-vascular disease</u>			
DUE TO (c) <u>-----</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Decubitus ulcers; Chronic Brain Syndrome</u>			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year <u>19</u>		20d INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6/8</u> , 19 <u>67</u> , to <u>11/6/</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11/6/</u> 19 <u>67</u> , and that death occurred at <u>8:15 M.</u> from causes on and on the date stated above.			
22a SIGNATURE <u>L. Benedict, M.D.</u>		22b DATE SIGNED <u>11/7/67</u>	
22c PHYSICIAN'S NAME (Type) <u>L. Benedict, M.D.</u>		22d ADDRESS <u>Crownsville State Hospital, Maryland</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b DATE THEREOF <u>11/12/67</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Allen Springs Cem.</u>		23d LOCATION (City or Town) (County) (State) <u>Claren Co., N.C.</u>	
24. FUNERAL DIRECTOR <u>George A. Klein</u>		25a REC'D BY REGISTRAR <u>1548 N.E. Houn St.</u>	
25b REGISTRAR'S SIGNATURE		DATE <u>NOV 2 1967</u>	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If city delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (1)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item #9 File #337-1172767 ph

14874

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14881

1 PLACE OF DEATH a COUNTY <u>A. A. Co.</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>MD</u> b COUNTY <u>AAO</u>	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>ANNAPOLIS -</u>		c LENGTH OF STAY IN 1b <u>ANNAPOLIS -</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>D.O.A. - ANNE ARUNDEL GENERAL</u>		d STREET ADDRESS <u>603 Ridge Rd.</u>	
3 NAME OF DECEASED (Type or print) <u>John B Wilson</u>		4 DATE OF DEATH Month <u>NOV</u> Day <u>18</u> Year <u>1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>7-11-48</u>
9 AGE in years <u>19</u> last birthday		IF UNDER 1 YEAR Months <u>7</u> Days <u>7</u> Hours <u>10</u> Min <u>0</u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self-employed</u>		10b KIND OF BUSINESS OR INDUSTRY <u>GROCERY</u>	
11 BIRTHPLACE (State or foreign country) <u>DENVER, COLORADO</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Charles Wilson</u>		14 MOTHER'S MAIDEN NAME <u>Eloise Grace Wheeler</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16 SOCIAL SECURITY NO <u>003-12-5045</u>	
17 INFORMANT <u>EVELYN L. WILSON</u>		Address <u>ANNAPOLIS, MD</u>	
18 CAUSE OF DEATH (Enter only one cause per PART. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac disease</u> <u>7344</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I <u> </u>			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 1B) <u> </u>	
20c TIME OF INJURY Month, Day, Year <u> </u> <u> </u> <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u> </u>	20f (City or town) (County) (State) <u> </u> <u> </u> <u> </u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhardt</u> EXAMINER'S NAME (Type) <u>E. Linhardt</u>		22 DATE SIGNED <u>NOV 18 - 1967</u>	
23a BURIAL, CREMATION, or REMOVAL (Specify) <u>BURIAL</u>		23b DATE THEREOF <u>11-22-67</u>	
23c NAME OF CEMETERY OR REMATORY <u>Hillcrest</u>		23d LOCATION (City or Town) (County) (State) <u>ANNAPOLIS AAO MD</u>	
24 FUNERAL DIRECTOR <u>TH Hordley 12 Ridgeley Ave, Annapolis, Md</u>		25a REC'D BY REGISTRAR <u>NOV 21 1967</u>	
		25b REGISTRAR'S SIGNATURE <u>John J. Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>AA. County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville S. Hosp. Inc.</u>		d. STREET ADDRESS <u>212 N. Fremont Ave.</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>WRIGHT, OLIVIA</u>		4. DATE OF DEATH Month <u>11</u> Day <u>4</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/7/85</u>
9. AGE (In years last birthday) <u>82 yrs.</u>		IF UNDER 1 YEAR Months <u>4</u> Days <u>4</u> IF UNDER 24 HRS. Hours <u>19</u> Min. <u>67</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John Loyinos</u>	
14. MOTHER'S MAIDEN NAME <u>Bettie Ward</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Elizabeth Johns</u> Address <u>905 W. Saratoga St.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> DUE TO <u>9049</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Septic Embolisation</u> DUE TO (c) <u>Fracture of @ Hip</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>Several days</u> <u>Since 10/16/67</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Decubitus ulcer of back</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. <u>19</u> Month, Day, Year p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11/3</u> , 19 <u>67</u> to <u>11/4</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11/2</u> , 19 <u>67</u> , and that death occurred at <u>0230 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Charles A. Greene, MD</u>		22b. DATE SIGNED <u>11/4/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Charles A. Greene, MD</u>		22d. ADDRESS <u>Johns Hopkins Hospital</u> <u>601 N. Bury - Baltimore MD 21205</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>Nov. 8, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arbutus Memorial Park</u>	23d. LOCATION (City or town) (County) (State) <u>Arbutus MD</u>
24. FUNERAL DIRECTOR <u>Williams Funeral Home</u>		25. REC'D BY REGISTRAR <u>3197 Schroeder St</u>	
25a. REGISTRAR'S SIGNATURE <u>William Jones</u>		25b. DATE <u>NOV 8 1967</u>	

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

County Coroner, Dr. Frederick was notified & he approved of this action. 10/11/67

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAUREL, MD		c. LENGTH OF STAY IN 1b 1 YR	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) KIMBROUGH ARMY HOSPITAL		d. STREET ADDRESS 509 SCHMIER RD, LAUREL MD.	
3. NAME OF DECEASED (Type or print) First JOHN Middle JOSEPH Last ZIDEK		4. DATE OF DEATH Month NOVEMBER Day 7 Year 19 67	
5. SEX MALE	6. COLOR OR RACE CAU	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT 2, 1902
9. AGE (In years last birthday) yrs. 65		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction Laborer		10b. KIND OF BUSINESS OR INDUSTRY Building	
11. BIRTHPLACE (County & State, or foreign country) EDEL, AUSTRIA		12. CITIZEN OF WHAT COUNTRY? AUSTRIA	
13. FATHER'S NAME JOHN JOSEPH ZIDEK		14. MOTHER'S MAIDEN NAME Mary ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 577-24-6992	
17. INFORMANT MARY ZIDEK-WIFE-		Address 509 SCHMIER RD, LAUREL MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CORONARY ARTERY ARTERIOSCHLEROSIS DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 4201			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 11	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> retired	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) DOA ON	20f. (City or town) (County) (State) NOV 7 19 67
21. I certify that (this hospital) attended the deceased from NOV 7 19 67 to NOV 7 19 67 from causes and on the date stated above.			
22a. SIGNATURE Louis A. Frederick		22b. DATE SIGNED 7 NOV 67	
22c. PHYSICIAN'S NAME (Type) LOUIS A. FREDERICK, CPT MC.		22d. ADDRESS KIMBROUGH ARMY HOSPITAL	
23a. BURIAL, CREMATION, or other disposition (Specify) Burial	23b. DATE THEREOF 11/10/67	23c. NAME OF CEMETERY OR CREMATORY Oak Hill	23d. LOCATION (City or Town) (County) (State) Washington D. C.
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE NOV 14 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

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